MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1 01794

CERTIFICATE OF DEATH 931 Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Mont. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Echo Heights. MARYLAND. LENGTH OF STAY (in this place) 14 yrs. HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Glen Echo Heights, Md. COUNTY Mont. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Echo Heights, Md. STREET ADDRESS (If rural, give location) 6541 Tuscarawas Rd.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	ANNIE	AMELIA	ARDINGER		Feb.	11,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
female	white	widowed	Apr. 14, 1875	73 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	at home	Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John H. Young	Sarah Foster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	---	none	Mary Alice Cooper (Daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic myocarditis associated with generalized arteriosclerosis	years.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Acute Bronchitis and dry pleurisy	2 wks.
	(c) Cholethiasis.	2 yr.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—				

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feb 2, 1949 to Feb 11, 1949, that I last saw the deceased alive on Feb 11, 1949, and that death occurred at 1:45 P. m. from the causes and on the date stated above.

SIGNATURE (Degree or title) C. P. Ryland M.D. ADDRESS C. P. RYLAND, M. D. 4901 MASSACHUSETTS AVE., N. W. WASHINGTON 16, D.C. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	2-14-49	Potomac Cemetery	Potomac, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-12-49	W E Jobes	W. W Chamber Co.	D.C.

RECEIVED
FEB 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 115 01795

CERTIFICATE OF DEATH 55a Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural) | LENGTH OF STAY (in this place) 29 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arlington
STREET ADDRESS (If rural, give location) 304 South Veitch Street ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
David	John	AUSTIN	February	20	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	W-US	single	10-23-48	3 yrs.	3	27		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Bethesda, Md.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: AUSTIN, Harold
14. MOTHER'S MAIDEN NAME: JAMES, Roberta

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: father: Mr. Harold Austin, CMS USN Active

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Neuroblastoma of left adrenal with widespread metastases

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 21, 1949, to Feb. 20, 1949, that I last saw the deceased alive on Feb. 20, 1949, and that death occurred at 6:05 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
A. M. MARGILETH, Lt JG MC USN, US Naval Hospital, Bethesda, Md. 2-21-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	2-23-49	Arlington National	Arlington, Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
2-23-49	Mary C. Patterson	W. W. CHAMBERS, Georgetown, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

A91

RECEIVED
FEB 24 1949
BUREAU V. S.

Evidence for changeof age is on:
FILM No. G 119 FEB 21 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital	STREET ADDRESS (If rural give location) 35 Lone Oak Dr.

3. NAME OF DECEASED (Type or Print)	(First) Frances	(Middle)	(Last) Baatz	4. DATE OF DEATH	(Month) 2	(Day) 12	(Year) 1949
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH June 1 1889	9. AGE last birthday 59 ~~xxx~~ yrs.	If under 1 year Months 5	Days 11	If under 24 hrs. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Budapest			12. CITIZEN OF WHAT COUNTRY? yes	
13. FATHER'S NAME Henry Blum			14. MOTHER'S MAIDEN NAME Henrietta Schwimmer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Walter A. Notton				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Generalized Abdominal Carcinoma	7 weeks
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma Splenic Flexure Colon	6 months
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Generalized Abdominal Carcinoma	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 6, 1949, to Feb. 12, 1949, that I last saw the deceased alive on Feb. 11, 1949, and that death occurred at 12:35 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title) ADDRESS	DATE SIGNED
C. Willard Camalier, Jr.	1801 - Eye St. N.W., Wash., D.C.	2/12/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 2/15/49	NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	LOCATION (City, town, or county) (State) Washington, D.C.
DATE REC'D BY LOCAL REG. 2-14-49	REGISTRAR'S SIGNATURE W. E. Jobes	24. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Md.	ADDRESS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
FEB 16 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01797

443

CERTIFICATE OF DEATH 938

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY: Montgomery; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural); LENGTH OF STAY (In this place): 1 day; HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Washington, D.C. COUNTY: ; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ; STREET ADDRESS (If rural, give location): 715 3rd St., N. W.

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) (Last) BALDINI	4. DATE OF DEATH: (Month) Feb. (Day) 25 (Year) 1949					
5. SEX: male	6. COLOR OR RACE: W-US	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: 3-15-89	9. AGE last birthday: 59 yrs.	If under 1 year: Months 11 Days 10	If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): cook	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Italy	12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: BALDINI, ? Italy		14. MOTHER'S MAIDEN NAME: unknown Italy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WWI	16. SOCIAL SECURITY NO.	17. INFORMANT: friend: Mrs. Mary Giusti, 419 Mass. Ave. Wash., D.C. N.W.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Embolism	12 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myocardial failure	?
	(c) Hypertensive Cardio Vascular Disease	?
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb. 24, 1949, to Feb. 25, 1949, that I last saw the deceased alive on Feb. 25, 1949, and that death occurred at 10:50A m., from the causes and on the date stated above.

SIGNATURE: D. E. Billman (Degree or title) ADDRESS: D. E. BILLMAN, Lt. JG MC USN, US Naval Hospital, Bethesda, Md. DATE SIGNED: 2-25-49

23. BURIAL, CREMATION REMOVAL (Specify): burial	DATE THEREOF: 3-1-49	NAME OF CEMETERY OR CREMATORY: Arlington Nat'l	LOCATION (City, town, or county) (State): Arlington, Va.	
DATE REC'D BY LOCAL REG.: 2-25-49	REGISTRAR'S SIGNATURE: Mary G. Patterson	24. FUNERAL DIRECTOR: W.W.CHAMBERS, 1400 Chapin St., N.W. Wash., D.C.	ADDRESS	

W. W. Chambers Hughes

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 153 462

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CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural)
LENGTH OF STAY (in this place): 4 mons. 8days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U. S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Conn. — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: East Hartford
STREET ADDRESS (If rural give location): 49 Knollwood Road ✓

3. NAME OF DECEASED (Type or Print): (First) Vincent (Middle) (Last) BENEDICT

4. DATE OF DEATH: (Month) February (Day) 14 (Year) 1949

5. SEX: male

6. COLOR OR RACE: W-US

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 7-9-81

9. AGE last birthday: 67 yrs. If under 1 year: Months 7 Days 5 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Navy

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Colo.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: BENEDICT, Jesse

14. MOTHER'S MAIDEN NAME: COLEMAN, Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If year, give war or dates of service): SpAm.WWI&II

16. SOCIAL SECURITY No.:

17. INFORMANT: wife: Mrs. Lillian C. Benedict

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Massive Intestinal Hemorrhage	2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinomatosis, abdominal	4 months
	(c) Carcinoma of Ascending Colon	2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 6, 1948, to Feb. 14, 1949, that I last saw the deceased alive on 14 Feb., 1949 and that death occurred at 8:34 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

L. J. POPE, Cdr. MC USN, US Naval Hospital, Bethesda, Md. 2-14-49

23. BURIAL, CREMATION, REMOVAL (Specify): burial
DATE: 2-16-49
NAME OF CEMETERY OR CREMATORY: Jordan Cemetery
LOCATION (City, town, or county) (State): Waterford, Conn.

DATE REC'D BY LOCAL REG.: 2-14-49
REGISTRAR'S SIGNATURE: Mary C. Patterson

24. FUNERAL DIRECTOR: S. H. HINES, 2901 14th St., N.W. Wash., D.C. ADDRESS

R.D.M

RECEIVED
FEB 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 420.1 94a

01799

CERTIFICATE OF DEATH

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY Montgomery — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Montgomery County General Hospital Inc.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Clarksville.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Ella (Middle) Grace (Last) Benson

4. DATE OF DEATH: (Month) February (Day) 13, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Dec. 28, 1856

9. AGE last birthday: 92 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home.

11. BIRTHPLACE (State or foreign country): Eastern Shore, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Wilson

14. MOTHER'S MAIDEN NAME: Sallie Caresley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Cardiac failure	3 days
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Coronary artery arteriosclerosis	20 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1947, to Feb 13, 1949, that I last saw the deceased alive on Feb 13, 1949, and that death occurred at 4:20 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Charles S. Whitaker M.D. — Clarksville, Maryland.

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 2/16/49 — NAME OF CEMETERY OR CREMATORY: Loudon Park — LOCATION (City, town, or county) (State): Balto Md

DATE REC'D BY LOCAL REG.: 2/14/49 — REGISTRAR'S SIGNATURE: A. W. Hedrick

24. FUNERAL DIRECTOR: Leonard J Ruck — ADDRESS: 5305 Harford Rd.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

420.1 93d 01800

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural) LENGTH OF STAY (in this place) 38 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Criglersville
HOSPITAL OR INSTITUTION OR STREET ADDRESS U S Naval Hospital	STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print)	(First) Charles	(Middle) Thurman	(Last) BERREY	4. DATE OF DEATH	(Month) February	(Day) 21	(Year) 1949
6. SEX male	6. COLOR OR RACE W-US	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 6-10-88	9. AGE last birthday 60 yrs.	If under 1 year Months 8 Days 11	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME John Berrey	14. MOTHER'S MAIDEN NAME Annie D. Utz						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) WWI	16. SOCIAL SECURITY No.	17. INFORMANT Wife: Mrs Mattie Berrey					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary infarction

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Congestive myocardial failure

(c) Coronary Heart Disease Arteriosclerotic

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 14, 1949, to Feb. 21, 1949, that I last saw the deceased alive on 21 Feb., 1949, and that death occurred at 4:10 P m., from the causes and on the date stated above.

SIGNATURE D. E. Billman Lt. (Degree or title) ADDRESS DATE SIGNED

D. E. BILLMAN, Lt. JG MC USN, US Naval Hospital, Bethesda, Md. 2-22-49

23. BURIAL, CREMATION REMOVAL (Specify) burial	DATE	NAME OF CEMETERY OR CREMATORY Shilo	LOCATION (City, town, or county) Culpeper, Va. (State)
DATE REC'D BY LOCAL REG. 2-22-49	REGISTRAR'S SIGNATURE Mary C. Patterson	24. FUNERAL DIRECTOR W.W. Chambers, 1400 Chapin St. N.W. Wash. D.C.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 26 1949
BUREAU V. S.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

200.1 55e

01801

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wheaton
LENGTH OF STAY (in this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS 11712 Grand View Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wheaton
STREET ADDRESS (If rural give location) 11712 Grand View Avenue

3. NAME OF DECEASED (Type or Print) (First) JOSEPH (Middle) ANTHONY (Last) BOWEN

4. DATE OF DEATH (Month) FEB (Day) 23 (Year) 1949

5. SEX MALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH DEC 21, 1884

9. AGE last birthday 64 yrs. If under 1 year Months — Days — If under 24 hrs. Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian

10b. KIND OF BUSINESS OR INDUSTRY Richmond Investment, Co. Cleve. Ohio

11. BIRTHPLACE (State or foreign country) England

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ANTHONY BALJAY

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service) —

16. SOCIAL SECURITY NO. 295-10-0904

17. INFORMANT EDGAR A. BOWEN

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Lympho-sarcoma (general)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dep. med. Exam. case, that I last saw the deceased alive on ....., 19....., and that death occurred at 5:10 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Frank J. Broschart, M.D. Dep. med. Exam

ADDRESS Gaithersburg Md

DATE SIGNED 2-23-49

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL

DATE Feb. 25, 1949

NAME OF CEMETERY ~~OR CREMATORY~~ Washington National

LOCATION (City, town, or county) (State) Suitland, Maryland

DATE REC'D BY LOCAL REG. Feb 23, 1949

REGISTRAR'S SIGNATURE Josephine M. Schaeffer

24. FUNERAL DIRECTOR W. W. CHAMBERS CO., ADDRESS 1400 Chapin St., N.W. WASHINGTON, D.C.

RECEIVED
FEB 28 1949
BUREAU OF E.

01802

420.1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

940 Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring — LENGTH OF STAY (in this place) 3 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location) 301 Normandy Dr.

3. NAME OF DECEASED (Type or Print): (First) Edith (Middle) Foster (Last) Boyd

4. DATE OF DEATH: (Month) Feb (Day) 17 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1 June 1890

9. AGE last birthday: 58 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Joshua ~~Boyd~~ Foster

14. MOTHER'S MAIDEN NAME: Gertrude Foster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Ellsworth Boyd

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Art. Thrombosis	11 hrs
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Art Schlerosis	one yr.
	(c) Essential Hypertension	15 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Obesity	15 yrs

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED ~~While at Work~~ ☐ ~~Not While At work~~ ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 17 Jan, 1949, to 17 Feb, 1949, that I last saw the deceased alive on 17 Feb, 1949, and that death occurred at 3:00 P m., from the causes and on the date stated above.

SIGNATURE: Merton L. White (Degree or title) MD ADDRESS: 9715 Georgia Ave SS. Md DATE SIGNED: 17 Feb 49

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE: 2-21-49 NAME OF CEMETERY OR CREMATORY: Arlington National LOCATION (City, town, or county) (State): Va.

DATE REC'D BY LOCAL REG.: Feb. 17, 1949 REGISTRAR'S SIGNATURE: Josephine M. Schaeffer 24. FUNERAL DIRECTOR: The S H Hines Co. ADDRESS: Wash. DC

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Md

RECEIVED
FEB 21 1949
BUREAU V. S.

01803

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D. C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural) LENGTH OF STAY (in this place) 1 mon. 10 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
HOSPITAL OR INSTITUTION OR STREET ADDRESS USNH, Bethesda, Maryland	STREET ADDRESS (If rural give location) 1509 Caroline St. N.W.

3. NAME OF DECEASED (Type or Print)	(First) James	(Middle) Henry	(Last) BROWN	4. DATE OF DEATH	(Month) 2	(Day) 26	(Year) 1949
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 4-8-97	9. AGE last birthday 51 yrs.	If under 1 year Months 10	Days 18	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME William Brown	14. MOTHER'S MAIDEN NAME Percilla Brown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) WW1	16. SOCIAL SECURITY NO.	17. INFORMANT Sister: Irene Brown, 1509 Caroline St. N.W. Washington, D.C.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Embolism, Pulmonary	2 weeks
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Heart Disease, arteriosclerotic	2 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [X] No [ ]
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work [ ] Not While At work [ ]	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 18, 1949, to Feb. 26, 1949, that I last saw the deceased alive on 26 Feb., 1949, and that death occurred at 4:25 A m., from the causes and on the date stated above.

SIGNATURE W. F. Queen (Degree or title) ADDRESS DATE SIGNED
Wm. F. QUEEN, Cdr. MC USN, US Naval Hospital, Bethesda, Md. 2-26-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 3-3-49	NAME OF CEMETERY OR CREMATORY Arlington National	LOCATION (City, town, or county) (State) Arlington, Va.
DATE REC'D BY LOCAL REG. 2-26-49	REGISTRAR'S SIGNATURE Mary C. Patterson Mary C. Patterson	24. FUNERAL DIRECTOR W.E. Jarvis, 1432 U.St.N.W.Wash.D.C.	ADDRESS

E.W.J.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 2 1949
BUREAU V. S.

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

444 01804

FILM No. G 119 MAR -8 1949 **CERTIFICATE OF DEATH** 96 Reg. Dist. No. 212

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Montgomery — STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Barnesville R.F.D. — LENGTH OF STAY (in this place): all life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Barnesville R.F.D.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Louis	W.	Brown	Feb.	23	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Colored	Married	8/13/1884	~~65~~ 64 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Maryland	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Louis Brown	Liddie Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hemorrhage from Ulcer	10 min
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Aneurysm of left innominate art.	6 mos
	(c) Hypertension	10 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
none				

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
none			m.		

22. I hereby certify that I attended the deceased from Sept., 1948 to 18 Feb., 1949, that I last saw the deceased alive on 18 Feb., 1949, and that death occurred at 6:10 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John F Fawcett	M.D.	P.O Boyds Md	23 Feb 49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/26/49	Barnesville	Barnesville, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/25/49	Mrs. C. C. Hilton by Mrs. W.B.H.	Robert L. Hawkins	Rockville Md

VS. A15

RECEIVED
MAR 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 332 01805

CERTIFICATE OF DEATH 83

Reg. Dist. No. 215

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS. A15

1. PLACE OF DEATH: COUNTY: Montgomery — STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Washington, D. C. — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural) — LENGTH OF STAY (In this place): 3 mons. 6da	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital	STREET ADDRESS (If rural give location): 1821 41st Place, S.E.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ernest		BRUNNER	February	11	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	W-US	married	6-27-90	58 yrs.	7	16		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
unemployed		Washington, D.C.	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
BRUNNER, Ernest	GRIMM, Kate

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no		wife: Mrs. Jennie E. Brunner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchopneumonia	2 wks.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Thrombosis	3 mos.
	(c) Arteriosclerosis, Generalized	years.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 5 Nov. 1948, to 11 Feb. 1949, that I last saw the deceased alive on 11 Feb. 1949, and that death occurred at 6:13 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wade H. Boswell — W. H. BOSWELL, Lt. MC USN, US Naval Hospital, Bethesda, Md. — 2-12-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	2-15-49	Cedar Hill	Suitland Road, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-12-49	Mary C. Patterson	W. W. Chambers Co.	517-11th St. S.E.

W. W. CHAMBERS, 517 11th St., S.E., Wash. D.C.

RECEIVED
FEB 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 420.1 01806

CERTIFICATE OF DEATH 93d

Reg. Dist. No. 213

1. PLACE OF DEATH: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville, rural; MARYLAND; LENGTH OF STAY (in this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville rural; STREET ADDRESS (If rural give location) Homer's Lane Extended.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Maurice	Calvin	Butt	Feb.	10	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	July 10, 1887	61 yrs.	7	0		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Government clerk	U.S.Govt.	Montgomery Co. Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robert McK. Butt	Rebecca Rickets

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes	WW I	none	Preston E. Butt (son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Coronary thrombosis	Five minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardiac dilatation & decompensation	1 year
(c) arteriosclerosis, chronic myocarditis	2 years.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
No.				

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 1944 to Feb. 10, 1949, that I last saw the deceased alive on Feb. 10, 1949, and that death occurred at 6.40 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm R. Smithson	M.D.	Rockville, Md.	2/10/49.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 13, 1949	Rockville Union	Rockville, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-12-49	E P Sloupman	Robert G. Dumphrey	Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 16 1949
BUREAU V. S.

EVIDENCE FOR CHANGE OF BIRTH DATE IS ON:

FILM No. G 119 MAR 31 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

442 01807

CERTIFICATE OF DEATH

131a Reg. Dist. No. 216

1. PLACE OF DEATH· COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Maryland COUNTY Montg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda — LENGTH OF STAY (in this place) 25 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 Winston Drive	STREET ADDRESS (If rural, give location) 16 Winston Drive

3. NAME OF DECEASED (Type or Print)	(First) Frank	(Middle) Nagle	(Last) Cantril	4. DATE OF DEATH	(Month) February (Day) 27 (Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH ~~Feb. 27, 1949~~ 6/9/56	9. AGE last birthday 92 yrs.	If under 1 year Months 8 Days 18 — If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Des Moines, Iowa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jacob Nagle	14. MOTHER'S MAIDEN NAME Zeruah Cooley				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. None	17. INFORMANT Mrs. Clifford A. Betts (Daughter)			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Respiratory Failure — 24 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Spastic Paralysis, Cerebral hemorrhage — 8 weeks

(c) Cardiac Failure; Hypertensive Cardiovascular disease — 3 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1947, to Feb 27, 1949, that I last saw the deceased alive on Feb 25, 1949, and that death occurred at 8:00 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank Y. Joggers Jr.	M.D.	5707 Wise Av. Chevy Chase Md.	2/27/49

23. BURIAL, CREMATION REMOVAL (Specify) Shipment	DATE 3/1/49	NAME OF CEMETERY OR CREMATORY Fairmont Cemetery	LOCATION (City, town, or county) Denver (State) Colo.
DATE REC'D BY LOCAL REG. 2-28-49	REGISTRAR'S SIGNATURE W. E. Jobes	24. FUNERAL DIRECTOR Robert A. Pumphrey	ADDRESS Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Wis. 2200

RECEIVED
MAR 3 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 350 87c

01808

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sans Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 1845 Calvert st. NW ✓

3. NAME OF DECEASED (Type or Print) (First) Margaret (Middle) R. (Last) Casey

4. DATE OF DEATH (Month) 2 (Day) 8 (Year) 1949

5. SEX Fe

6. COLOR OR RACE whit, Amer

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Separated

8. DATE OF BIRTH 11-4-1905

9. AGE last birthday 43 yrs. If under 1 year Months. Days. If under 24 hrs. Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.

11. BIRTHPLACE (State or foreign country) Buffalo, N.Y.

12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME George Reckenberger

14. MOTHER'S MAIDEN NAME Unk. ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Pts. Chart.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Malnutrition - Inanition	months
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Parkinson's Syndrome	5+ years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 7, 1949, to Feb 8, 1949, that I last saw the deceased alive on Feb 8, 1949, and that death occurred at 4:25 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Robert A Harned M.D. (with corner's consent) Takoma Park, Md. 2/8/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE Feb 9 NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State) Portville, N.Y.

DATE REC'D BY LOCAL REG. 2/9/49 REGISTRAR'S SIGNATURE John W Dodd

24. FUNERAL DIRECTOR E. A. Hines Co. ADDRESS 2901-14th St N.W. Wash. D.C.

RECEIVED
FEB 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

332

CERTIFICATE OF DEATH

83b

Reg. Dist. No. 215 01809

1. PLACE OF DEATH · COUNTY MONTGOMERY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE District of Columbia, COUNTY D. C.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural) — LENGTH OF STAY (in this place) 12 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital	STREET ADDRESS (If rural give location) 711 7th St., S.E.

3. NAME OF DECEASED (Type or Print) (First) Thomas	(Middle) Francis	(Last) CLARKSON	4. DATE OF DEATH (Month) February	(Day) 20	(Year) 1949
5. SEX male	6. COLOR OR RACE W-US	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH 1-27-71	9. AGE last birthday 78 yrs.	If under 1 year Months 0 Days 22 — If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Conn.	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME CLARKSON, John		14. MOTHER'S MAIDEN NAME TWIBBLE, Ann			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes — (If year, give war or dates of service) Sp.Am.	16. SOCIAL SECURITY NO.	17. INFORMANT daughter: Miss Gladys M. Clarkson			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Thrombosis, lt.mid. cerebral artery	3 wks
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	unknown
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 7, 1949, to Feb. 20, 1949, that I last saw the deceased alive on Feb. 20, 1949, and that death occurred at 12:35 Am., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wade H. Boswell

W. H. BOSWELL, Lt MC/USN, US Naval Hospital, Bethesda, Md. 2-20-49

23. BURIAL, CREMATION REMOVAL (Specify) burial	DATE 2-23-49	NAME OF CEMETERY OR CREMATORY Cedar Hill	LOCATION (City, town, or county) (State) Washington, D. C.
DATE REC'D BY LOCAL REG. 2-20-49	REGISTRAR'S SIGNATURE Mary C. Patterson	24. FUNERAL DIRECTOR LEE FUNERAL HOME	ADDRESS 4th & Mass Ave. Wash.

John E Ott

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
MAR 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

-334 832

01810

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural)
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Washington, D. C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location) 2311 Connecticut Avenue ✓

3. NAME OF DECEASED (Type or Print) (First) Dora (Middle) Allen (Last) CONARD

4. DATE OF DEATH (Month) Feburary (Day) 21 (Year) 1949

5. SEX FEMALE female

6. COLOR OR RACE W-US

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH 10-5-73

9. AGE last birthday 75 yrs. If under 1 year Months 4 Days 16 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Japan

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME ALLEN, Robert W.

14. MOTHER'S MAIDEN NAME Dora ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT husband: R.Adm.Charles Conard, USN Ret.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hgmrt — Interval between onset and death: 5 wks.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized atherosclerosis

(c) Hypocardiac failure

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 17, 1949, to Feb. 21, 1949, that I last saw the deceased alive on Feb. 21, 1949, and that death occurred at 1 A m., from the causes and on the date stated above.

SIGNATURE E. M. SPAULDING, (Degree or title) CDR MC USN, ADDRESS US Naval Hospital, Bethesda, Md. DATE SIGNED 2-21-49

23. BURIAL, CREMATION REMOVAL (Specify) burial

DATE 2-24-49

NAME OF CEMETERY OR CREMATORY Arlington National

LOCATION (City, town, or county) (State) Arlington, Va.

DATE REC'D BY LOCAL REG. 2-21-49

REGISTRAR'S SIGNATURE Mary C. Patterson Mary C. Patterson

24. FUNERAL DIRECTOR R.J.H. Joseph Gawler, ADDRESS 1756 Penn.Ave.,N.W., Wash.,D.C.

RECEIVED
MAR 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 443 01811

CERTIFICATE OF DEATH 93d

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney
LENGTH OF STAY (In this place) 11 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Montgomery County General Hospital, Inc.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg R.F.D. # 2
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) E. (Last) Copelin

4. DATE OF DEATH: (Month) February (Day) 5 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 31, 1904

9. AGE last birthday: 44 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Prather

14. MOTHER'S MAIDEN NAME: Martha Claggett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Congestive Heart Failure	Undet.
Antecedent cause(s)	Hypertensive Encephalopathy	2 days
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardio Vascular Disease.	Undet
	(c) Obesity	Undet.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 1949, to Feb. 5, 1949, that I last saw the deceased alive on Feb. 5, 1949, and that death occurred at 4:29 A.m., from the causes and on the date stated above.

SIGNATURE Jack Schumacher (Degree or title) M. D. ADDRESS Laytonsville, Maryland DATE SIGNED 2/5/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE Feb 8 1949 NAME OF CEMETERY OR CREMATORY Brookgrove LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. February 7-49 REGISTRAR'S SIGNATURE Gertrude B Fawler

24. FUNERAL DIRECTOR Roy W Barber Jr Laytonsville Md ADDRESS

RECEIVED
FEB 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 332

01812

CERTIFICATE OF DEATH 94a

Reg. Dist. No. 716

M

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

I

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VS. A15

1. PLACE OF DEATH: COUNTY: Montgomery; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Chevy Chase; LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 4705 Dalton Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Chevy Chase; STREET ADDRESS (If rural give location): 4705 Dalton Road

3. NAME OF DECEASED (Type or Print): (First) Laurence (Middle) William (Last) Coudray

4. DATE OF DEATH: (Month) February (Day) 19 (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~ (Specify): Widowed

8. DATE OF BIRTH: December 30, 1870

9. AGE last birthday: 78 yrs. If under 1 year: Months 1 Days 19; If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Woodstock Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Henry Coudray

14. MOTHER'S MAIDEN NAME: Adella Butler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Robert C. Coudray

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral thrombosis	10 mimutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Atteriosclerosis, general	10 years
	(c) Arteriosclerosis, cerebral and coronary	10 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Cardiac decompensation	3 years

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: ---

20. AUTOPSY? Yes ☐ No ☒ X

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: ---- (CITY OR TOWN): ---- (COUNTY): ---- (STATE): ----

TIME OF INJURY (Month) (Day) (Year) (Hour): ---- m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from August 8, 1949, to Feb. 19, 19 49, that I last saw the deceased alive on Feb. 15, 19 49, and that death occurred at 6:41 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Robert G. Angle M.D. 106 Del Ray Avenue, Bethesda, Maryland Feb. 19, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE: Feb. 22, 1949 NAME OF CEMETERY OR CREMATORY: Cedar Hill LOCATION (City, town, or county) (State): Suitland, Prince George, Md.

DATE REC'D BY LOCAL REG. 2-20-49 REGISTRAR'S SIGNATURE: WE Jobe

24. FUNERAL DIRECTOR ADDRESS: Warner E. Pumphrey Inc. 8434 Georgia Ave. Silver Spring, Md.

RECEIVED
FEB 22 1949
BUREAU V. S.

01813

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1

CERTIFICATE OF DEATH

93d Reg. Dist. No. 216

1. PLACE OF DEATH · COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN — LENGTH OF STAY (in this place) 1 day + 9 hrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital	STREET ADDRESS (If rural give location) 5002 Dalton Rd.

3. NAME OF DECEASED (Type or Print) (First) Sarah (Middle) Elizabeth (Last) Crampton			4. DATE OF DEATH (Month) 2 (Day) 22 (Year) 1949			
5. SEX H	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Feb. 7th 1889	9. AGE last birthday 60 yrs.	If under 1 year Months / Days 14	If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wash. D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James Perry			14. MOTHER'S MAIDEN NAME Sarah Ward			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Leonard Crampton (Husband)			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial infarction	30 HOURS
Antecedent cause(s)	(b) Coronary artery thrombosis	4 DAYS?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Hypertensive cardiovascular disease	UNKNOWN

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-20, 1949, to 2-22, 1949 that I last saw the deceased alive on 2-22, 1949, and that death occurred at 6:20 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James E Boyland, M.D.		Suburban Hospital	2/22/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb. 25, 1949	Arlington National	Arlington,	Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-22-49	W. E. Jobes	Th. S. H. Hines C.	2901 14th Mt W Washington D C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
FEB 24 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.2 948

01814

CERTIFICATE OF DEATH

Reg. Dist. No. 213

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH

COUNTY: Montgomery | STATE: Md. (MARYLAND)

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Md. | COUNTY: Montgomery

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville

STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Richard (Middle) W. (Last) Crutchfield

4. DATE OF DEATH: (Month) Feb (Day) 16 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 24, 1884

9. AGE last birthday: 64 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Fredericksburg, Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Richard Crutchfield

14. MOTHER'S MAIDEN NAME: Alice Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: [illegible]

17. INFORMANT: Lottie Crutchfield (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Stroke of Apoplexy	½ hr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) angina Pectaris	6 Mos
	(c) Arteriosclerosis	2 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 15, 1949, to Feb 15, 1949, that I last saw the deceased alive on Feb 15, 1949, and that death occurred at 6 P.A. m., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title): MD ADDRESS: Gaithersburg DATE SIGNED: Feb 17/49

23. BURIAL, CREMATION, REMOVAL (Specify): | DATE: 2/18/49 | NAME OF CEMETERY OR CREMATORY: White | LOCATION (City, town, or county): Rockville | (State): Md.

DATE REC'D BY LOCAL REG.: 2-18-49 | REGISTRAR'S SIGNATURE: E R Thompson

24. FUNERAL DIRECTOR: Robert F. Snowden | ADDRESS: Rockville, Md.

RECEIVED
FEB 21 1949
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

181 52 b 01815

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural); LENGTH OF STAY (in this place) 2 mons. 14 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY PG; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cheverly; STREET ADDRESS (If rural give location) 2815 Belvue Avenue

3. NAME OF DECEASED (Type or Print): (First) George William Joseph (Middle) DAN (Last) JUNAS

4. DATE OF DEATH: (Month) February (Day) 15 (Year) 1949

5. SEX: male

6. COLOR OR RACE: W-US

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 10-17-99

9. AGE last birthday: 49 yrs. If under 1 year: Months 3, Days 28, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Navy

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: DAN JUNAS, Nichodumas

14. MOTHER'S MAIDEN NAME: DISKART, Caroline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If year, give war or dates of service): WWII

16. SOCIAL SECURITY NO.:

17. INFORMANT: wife: Mrs. Isabel Dan Junas

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Carcinoma of Urinary Bladder	3½ yrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pelvic Abscess	recent
	(c) Pyelonephritis	recent

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 12-21-48

19b. MAJOR FINDINGS OF OPERATION: Excision of lymphnodes in rt. groin

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1, 1948, to Feb. 15, 1949, that I last saw the deceased alive on Feb. 15, 1949, and that death occurred at 6 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

R. L. May

R. L. MAY, Lt MC USN, US Naval Hospital, Bethesda, Md. 2-15-49

23. BURIAL, CREMATION REMOVAL (Specify): burial; DATE: 2-18-49; NAME OF CEMETERY OR CREMATORY: Arlington National; LOCATION (City, town, or county) (State): Arlington, Va.

DATE REC'D BY LOCAL REG. 2-15-49; REGISTRAR'S SIGNATURE: Mary C. Patterson

24. FUNERAL DIRECTOR ADDRESS: W. W. CHAMBERS, Riverdale, Md.

Per JRW

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
FEB 17 1949
BUREAU V. S.

01816

151
46b

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH · COUNTY: Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Virginia COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural) — LENGTH OF STAY (in this place): 5 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Arlington
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital	STREET ADDRESS (If rural give location): 3722 S. 16th St.

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Wyatt (Last) DAVIS			4. DATE OF DEATH (Month) February (Day) 28 (Year) 1949		
5. SEX: male	6. COLOR OR RACE: W-US	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married	8. DATE OF BIRTH: 5-25-91	9. AGE last birthday: 57 yrs.	If under 1 year: Months 9, Days 3; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plummer	10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Virginia	12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: DAVIS, John E.			14. MOTHER'S MAIDEN NAME: SELLARS, Blanche		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If year, give war or dates of service): WWI	16. SOCIAL SECURITY NO.		17. INFORMANT: wife: Mrs. Alena Davis		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchopneumonia	4 days
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of stomach with	1 yr.
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION: Dec. 48	19b. MAJOR FINDINGS OF OPERATION: Surgical Exploratory	20. AUTOPSY? Yes X No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 23 Feb., 1949, to 28 Feb., 1949, that I last saw the deceased alive on Feb. 28, 1949, and that death occurred at 6:35 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J. M. Hanner	J. M. HANNER, Cdr. MC USN,	US Naval Hospital, Bethesda, Md.	3-1-49

23. BURIAL, CREMATION REMOVAL (Specify): burial	DATE: 3-3-49	NAME OF CEMETERY OR CREMATORY: Columbia Garden	LOCATION (City, town, or county) (State): Arlington, Va.
DATE REC'D BY LOCAL REG.: 3-1-49	REGISTRAR'S SIGNATURE: Mary C. Patterson	24. FUNERAL DIRECTOR: Ives Funeral Home,	ADDRESS: 2847 Wilson Blvd. Arl., Va.

J. C. G.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 5 1949
BUREAU V. S.

01817

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

420.1
92b

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MONTGOMERY - FAIRWAY Hills, Md

City or town 6202 WAGNER LANE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 YRS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY

City or town FAIRWAY Hills, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6202 WAGNER LANE, FAIRWAY Hills Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME MR. JOHN FRANCIS DEARNESS

3. (b) Social Security Number

4. Sex: Male

5. Color or race: W

6.(a) Single, married, widowed, or divorced: MARRIED.

6.(b) Name of ~~husband~~ or wife IRENE K. DEARNESS

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 30 - 1877

8. AGE: Years 71 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace OHIO
(Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business GOV'T WORKER

FATHER
12. Name WILLIAM DEARNESS
13. Birthplace

MOTHER
14. Maiden name AGNES PARKER
15. Birthplace

16. Informant MRS I. K. DEARNESS
Address 6202 WAGNER LANE

17. Burial (Burial, cremation, or removal, Which?) Date thereof MAR 1 - 49 (month) (day) (year)

Cemetery or crematory SPRING GROVE

Location CINCINNATI, OHIO

18. Funeral director Jos. Gusler's Sons
Address 1756 Pa. Ave NW

19. 2/28 1949 (Date rec'd by registrar) N. E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1949, at 4:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~February~~ Aug. 8 1945 to Feb. 28 1949 and that I last saw him alive on February 28 1949

Immediate cause of death Coronary thrombosis — DURATION 3 hours

Due to Arteriosclerosis generalized, severe with involvement of coronary arteries, ~~and~~ aorta, arteries of lower extremities and cerebral arteries — 11 yrs.

Other conditions Mitral stenosis with insufficiency, rheumatic — 50 yrs.
(Include pregnancy within 3 months of death)

Major findings of operations NONE

Date of op.

Autopsy results NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thomas A. Wildman M.D. M. D. or other

Address 3731 Morrison St. NW Washington 15, D.C. Date signed 2/28/49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 2 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 331 01818

CERTIFICATE OF DEATH 83a

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural); LENGTH OF STAY (in this place) ½ hour
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase
STREET ADDRESS (If rural, give location) 4615 Norwood Drive

3. NAME OF DECEASED (Type or Print): (First) Josephine (Middle) Anita (Last) DORSEY

4. DATE OF DEATH: (Month) February (Day) 11 (Year) 1949

5. SEX: female

6. COLOR OR RACE: W-US

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 1-19-80

9. AGE last birthday: 69 yrs. If under 1 year: Months 0 Days 22 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Mo.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: PORTS, Gidion W.

14. MOTHER'S MAIDEN NAME: TEMMENS, Anna

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: husband: Captain Arthur B. Dorsey, USN Ret.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Massive Cerebral Hemorrhage

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11 Feb., 1949, to 11 Feb., 1949, that I last saw the deceased alive on 11 Feb., 1949, and that death occurred at 10:33 A.m., from the causes and on the date stated above.

SIGNATURE I. L. V. Norman — (Degree or title) I. L. V. NORMAN, Capt. MC USN — ADDRESS US Naval Hospital, Bethesda, Md. — DATE SIGNED 2-11-49

23. BURIAL, CREMATION REMOVAL (Specify) burial | DATE THEREOF 2-15-49 | NAME OF CEMETERY OR CREMATORY Arlington National | LOCATION (City, town, or county) Arlington, Va. (State)

DATE REC'D BY LOCAL REG. 2-11-49 | REGISTRAR'S SIGNATURE Mary C. Patterson | 24. FUNERAL DIRECTOR Joseph Gawler & Sons, 1756 Penn. Ave., N.W. Wash., D.C. ADDRESS

Jos Gawler's Sons

VS. A15

RECEIVED
FEB 15 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

422.2
93d 01819

Reg. Dist. No. 2-17

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Unity
LENGTH OF STAY (In this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.F.D. Brookville

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Unity-R.F.D. Brookville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Sue (Middle) Burton (Last) Dwyer

4. DATE OF DEATH: (Month) 2 (Day) 22 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Aug. 4, 1851

9. AGE last birthday: 97 yrs. If under 1 year: Months 6, Days 18. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Tridelphia, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Basil Burton

14. MOTHER'S MAIDEN NAME: Lucinda DuVal

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: M. D. Elkins (daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) acute cardiac failure	2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) chronic myocarditis	15 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 1, 1949, to Feb 22, 1949, that I last saw the deceased alive on Feb 21, 1949, and that death occurred at 10:30 Pm., from the causes and on the date stated above.

SIGNATURE (Degree or title): Charles S. Whitelaw M.D. ADDRESS: Clarksville, Maryland DATE SIGNED: 2/23/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: Feb. 25, 1949
NAME OF CEMETERY OR CREMATORY: Ivy Hill
LOCATION (City, town, or county) (State): Laurel, Md.

DATE REC'D BY LOCAL REG.: 2-24-49
REGISTRAR'S SIGNATURE: Gertrude B Lawler

24. FUNERAL DIRECTOR: Robert A. Dumphrey ADDRESS: Bethesda, Md.

RECEIVED
MAR 11 1949
BUREAU V. R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

420.1 94n

01820

CERTIFICATE OF DEATH

Reg. Diat. No. 216

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County MONTGOMERY

City or town ROCKVILLE MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 YRS.

Hospital, Institution, or street address where death occurred:

WAVERLEY SANITARIUM

How long in hospital or institution? 8 YRS.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MONTGOMERY

City or town ROCKVILLE

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1275 ROCKVILLE PIKE

RURAL (If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME MRS. LAURA WOLCOTT JACKSON EKENGREN

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife WILHELM A.F. EKENGREN

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) AUG. 1870

8. AGE: Years 78 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace NEWARK New Jersey

(Town, county, and state)

10. Usual occupation NONE

11. Industry or business

FATHER 12. Name JOHN P. JACKSON

13. Birthplace NEWARK, N.J.

MOTHER 14. Maiden name CLARA CATLIN GREGORY

15. Birthplace NEW YORK

16. Informant MRS. ELSIE EKENGREN O'DUNNE

Address 1602 - 32nd St, N.W. WASH. D.C.

17. CREMATION Date thereof FEB. 14 1949

(Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Suitland Md.

18. Funeral director Joseph Gawler's Sons, Inc.

Address 1756 Pa. Ave., N.W. Wash. 6, D.C.

19. 2-13-49 19 ..... WE Jones Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1949, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1944 to Feb. 12 1949

and that I last saw h..... alive on February 11th 1949

Immediate cause of death — Coronary thrombosis — DURATION 10 minutes

Due to Arteriosclerosis 4 years

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Wallace Duff M.D.

M. D. or other

Address Bethesda, Md. Date signed Feb. 12-49

RECEIVED
FEB 15 1949
BUREAU V. S.

01821

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

754.4

CERTIFICATE OF DEATH

157e

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural) — LENGTH OF STAY (in this place) 3 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital	STREET ADDRESS (If rural, give location) 1839 E St., N. E.

3. NAME OF DECEASED (Type or Print)	(First) Thomas	(Middle) Michael	(Last) ECKENROD	4. DATE OF DEATH	(Month) February (Day) 21 (Year) 1949
5. SEX male	6. COLOR OR RACE W-US	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 2-18-49	9. AGE last birthday yrs.	If under 1 year Months / Days 3 — If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bethesda, Md.	12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME ECKENROD, Wilbert Frank			14. MOTHER'S MAIDEN NAME ~~[illegible]~~ PERRY, Joanne HOPE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.		17. INFORMANT father: Sgt. Wilbert F. Eckenrod, USMC		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Congenital Heart Disease

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Anomaly of Heart

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 18, 1949, to Feb. 21, 1949, that I last saw the deceased alive on Feb. 21, 1949, and that death occurred at 8:55 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
A. M. Margileth	A. M. MARGILETH, Lt. JG MC USN,	US. NAVAL HOSPITAL, Bethesda, Md.	2-21-49

23. BURIAL, CREMATION REMOVAL (Specify) burial	DATE THEREOF 2-23-49	NAME OF CEMETERY OR CREMATORY Arlington National	LOCATION (City, town, or county) (State) Arlington, Va.
DATE REC'D BY LOCAL REG. 2-21-49	REGISTRAR'S SIGNATURE Mary C. Patterson	24. FUNERAL DIRECTOR W. W. CHAMBERS, 517 11th St., S.E., Wash., D.C.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 21 1949
BUREAU T. S.

01822

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

470
106a

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Gaithersburg
LENGTH OF STAY (in this place) 43 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Gaithersburg md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) MARGARET (Middle) — (Last) EDENS

4. DATE OF DEATH (Month) Feb (Day) 7 (Year) 1949

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Dec 26-1948
9. AGE last birthday yrs. If under 1 Months. 1 year 12 Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jos. Henry Edens
14. MOTHER'S MAIDEN NAME Ovieda Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) ✓
16. SOCIAL SECURITY NO. ✓
17. INFORMANT Robert Moore

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Bronchitis.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) cold

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 5, 1949, to Feb 7, 1949, that I last saw the deceased alive on Feb 7, 1949, and that death occurred at 4 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) [signature] ADDRESS Gaithersburg md DATE SIGNED Feb 8, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Feb 9-1949
NAME OF CEMETERY OR CREMATORY Naylonsville md
LOCATION (City, town, or county) Montgomery co md (State)

DATE REC'D BY LOCAL REG. 2/9/49
REGISTRAR'S SIGNATURE L. D. Bell
24. FUNERAL DIRECTOR Roy W. Barber ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 12 1949
BUREAU V. S.

01823

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

443

CERTIFICATE OF DEATH

93a Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place) 1 day 1 hr. 40 min.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
STREET ADDRESS (If rural give location) 4838 Del Ray Ave.

3. NAME OF DECEASED (Type or Print) (First) Thomas (Middle) Joseph (Last) Elward

4. DATE OF DEATH (Month) 2 (Day) 24 (Year) 1949

5. SEX M
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Jan. 29, 1893
9. AGE last birthday 56 yrs. If under 1 year Months Days 25 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothier
10b. KIND OF BUSINESS OR INDUSTRY Clothier
11. BIRTHPLACE (State or foreign country) Wyoming, Pa.
12. CITIZEN OF WHAT COUNTRY U.S.

13. FATHER'S NAME Thomas Elward
14. MOTHER'S MAIDEN NAME Elizabeth Lamb.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) World War No. 1
16. SOCIAL SECURITY NO.
17. INFORMANT Elizabeth Elward (Daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 27 Hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Heart Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-29-, 1947, to 2-23, 1949, that I last saw the deceased alive on 2-23, 1949, and that death occurred at 4:25 A.m., from the causes and on the date stated above.

SIGNATURE W. Joyce (Degree or title) M.D. ADDRESS 546 Maple Ridge Rd, Bethesda, Md DATE SIGNED 2-24-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 2/26/49
NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery
LOCATION (City, town, or county) Washington (State) D.C.

DATE REC'D BY LOCAL REG. 2-25-49
REGISTRAR'S SIGNATURE W. E. Jobes
24. FUNERAL DIRECTOR Robert A. Humphrey - Bethesda, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 28 1949
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

443 01824

CERTIFICATE OF DEATH 932

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural) — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Branchville
STREET ADDRESS (If rural give location): 8907 49th AVE.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Leonard	(n)	EXEL		2	27	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	W-US	Married	2-10-08	41 yrs.	0	17		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Leonard Exel — D.C.
14. MOTHER'S MAIDEN NAME: Cathrine Teske — DC.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If year, give war or dates of service): WWII
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wife: Mrs. Myrtle Fay Exel

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hypertensive Heart Disease	1 yr
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Uremia	2 mos
	(c) Hypertension	4 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 19, 1949, to Feb. 27, 1949, that I last saw the deceased alive on Feb. 27, 1949, and that death occurred at 5 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): John W. Flynn
ADDRESS: John W. FLYNN, Lt. JG MC USN, US Naval Hospital, Bethesda, Md.
DATE SIGNED: 2-27-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	3-3-49	Arlington National	Arlington, Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-27-49	Mary C. Patterson	W.W. Chambers, Riverdale, Maryland	

RECEIVED
MAR 1 1949
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1 01825

CERTIFICATE OF DEATH 94a

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington | LENGTH OF STAY (In this place) 3 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Own Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington
STREET ADDRESS (If rural, give location) 11 Howard Ave.

3. NAME OF DECEASED (Type or Print): (First) Joseph Westerfield (Middle) — (Last) Farrell

4. DATE OF DEATH: (Month) Feb. (Day) 5 (Year) 1949

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: June 16, 1881 | 9. AGE last birthday: 67 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard | 10b. KIND OF BUSINESS OR INDUSTRY: U.S. Public Health - Kentucky | 11. BIRTHPLACE (State or foreign country): USA | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Farrell

14. MOTHER'S MAIDEN NAME: Sallie Westerfield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes | (If year, give war or dates of service): WW 1

16. SOCIAL SECURITY NO.: yes # ?

17. INFORMANT: Clemmie O. Farrell (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary thrombosis Acute	2-3 Hr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis Generized	yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/4/49, 19....., to 2/4/49, 19....., that I last saw the deceased alive on 2/4/49, 19....., and that death occurred at 3 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Samuel Allen M.D. Kensington Md. 2/5/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Feb. 9, 1949 | NAME OF CEMETERY OR CREMATORY: Arlington National | LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG. 2-5-49 | REGISTRAR'S SIGNATURE: W E Jobes | 24. FUNERAL DIRECTOR: Robert A. Dumphrey. | ADDRESS: Bethesda, Md.

RECEIVED
FEB 7 1949
BUREAU V. S.

01826

170

50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH· COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda — LENGTH OF STAY (In this place) 1 yr.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rest Home 9100 Old Georgetown Rd.	STREET ADDRESS (If rural give location) 5511 Oakmont Ave.

3. NAME OF DECEASED (Type or Print)	(First) Florence	(Middle) Hobbs	(Last) Fenn	4. DATE OF DEATH	(Month) Feb.	(Day) 1	(Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct. 7 1900	9. AGE last birthday 48 yrs.	If under 1 year Months 3	Days 24	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own-Home.	11. BIRTHPLACE (State or foreign country) Tarkio, Missouri	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Ralph C. Rouse	14. MOTHER'S MAIDEN NAME Vesta Pursell						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) No	16. SOCIAL SECURITY NO. 346-20-5986	17. INFORMANT Husband-Leonard S. Fenn					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinomatosis	May 44
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of the breast	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 15 May 1944	19b. MAJOR FINDINGS OF OPERATION Ca of Rt Breast	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ~~1947~~, 1945, to 17 Feb, 1949, that I last saw the deceased alive on 30 Jan, 1949, and that death occurred at 12:20 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Edward C. Wilson Jr MD

23. BURIAL, CREMATION REMOVAL (Specify) Burial-Transit	DATE 2/5/49	NAME OF CEMETERY OR CREMATORY Rosedale Cemetery	LOCATION (City, town, or county) (State) Payette, Idaho
DATE REC'D BY LOCAL REG. 2-1-49	REGISTRAR'S SIGNATURE W. C. Jobes	24. FUNERAL DIRECTOR Robert A. Pumphrey	ADDRESS Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01827

344

CERTIFICATE OF DEATH 87

Reg. Dist. No. 714

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery County MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park 12, Md. | LENGTH OF STAY (In this place) 1 hour
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium + Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural give location) 10007 Quinby Court

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) (Last) Flowers

4. DATE OF DEATH: (Month) Feb. (Day) 17 (Year) 1949

5. SEX: Female | 6. COLOR OR RACE: Caucasian | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single | 8. DATE OF BIRTH | 9. AGE last birthday: 4 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Washington, D.C. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph D. Flowers

14. MOTHER'S MAIDEN NAME: Helen L. Altonaw

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Internal hydrocephalus — 4 1/2 yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Upper respiratory infection producing — 3 wks

(c) Meningitis pneumococcic conditions — 4 1/2 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes [X] No [ ]

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work [ ] Not While At work [ ] | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 22, 1949, to Feb. 17, 1949, that I last saw the deceased alive on Feb. 17, 1949, and that death occurred at 1:10 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Frank A. Zack M.D. 8248 Ga. Ave. Silver Spring Md 2-17-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE Feb. 21, 1949 | NAME OF CEMETERY OR CREMATORY Cedar Hill | LOCATION (City, town, or county) Ft. Lee Co | (State) Md

DATE REC'D BY LOCAL REG. Feb. 17, 1949 | REGISTRAR'S SIGNATURE Josephine C. Schaeffe | 24. FUNERAL DIRECTOR J. Wm. Lee's Son Co. | ADDRESS 300-4th St. N.E.

RECEIVED
FEB 21 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 420.1 01828

CERTIFICATE OF DEATH 94a Reg. Dist. No. 414

M The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Mont, MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Mont.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Springs; LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Springs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2406 Birch Drive	STREET ADDRESS (If rural give location) 2406 Birch Drive

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Charles	Nye	Fraser	Feb	28	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	white	Married	July 3, 1877	71 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired salesman		Wash. D.C.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Francis L. Fraser	Cristina Bates

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
no	none	Frank Fraser (Son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	died suddenly
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec 19 Mrd. From Exam only, 19, that I last saw the deceased alive on ..., 19..., and that death occurred at 1:20 P.m., from the causes and on the date stated above.

SIGNATURE Frank J. Bouchait M. D. (Degree or title) ADDRESS Gaithersburg Md DATE SIGNED Dep med Exam.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/2/49	Colesville	Colesville, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Mar 1, 1949	Josephine M. Schaffe	Warner E. Waters, Enc. Perry Mey Chas Sons & Perry, Md	

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VS. A15

RECEIVED
MAR 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

776 01829

CERTIFICATE OF DEATH 159

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) 1 day, 2 hrs, 14 min
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington San & Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 219 Rock Creek Church ✓

3. NAME OF DECEASED (Type or Print): (First) Baby boy (Middle) Michael (Last) Gallagher

4. DATE OF DEATH: (Month) February (Day) 18 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: white. Amer

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: Feb. 17, 1949

9. AGE last birthday yrs. | If under 1 year: Months. | Days 4 | If under 24 hrs.: Hours 2 | Min. 14

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland – Mont. Co.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Joseph Gallagher

14. MOTHER'S MAIDEN NAME: Marion Eunice Rowe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mothers Chart

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Prematurity.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: (CITY OR TOWN) Takoma Park. (COUNTY) Montgomery (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 2-18 3 PM, 1949, to 2-18 10:35, 1949, that I last saw the deceased alive on 2-18, 1949, and that death occurred at 10 35 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Ruth Handcock md ADDRESS 904 Ellsworth Dr. Silver Spring DATE SIGNED 2-19-49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE 2/19/49 | NAME OF CEMETERY OR CREMATORY Mt Olivet | LOCATION (City, town, or county) (State) Washington D.C.

DATE REC'D BY LOCAL REG. 2/19/49 | REGISTRAR'S SIGNATURE J. Wilson Todd

24. FUNERAL DIRECTOR Francis J. Collins ADDRESS 3821-14th St. N.W. Wash. D.C.

RECEIVED
FEB 21 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01830

416
951

CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY MONTGOMERY | STATE MARYLAND | LENGTH OF STAY (in this place) 17 yrs
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BETHESDA
HOSPITAL OR INSTITUTION OR STREET ADDRESS 109 E. GLENBROOK Rd. BETHESDA

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND | COUNTY MONGOMERY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda Maryland
STREET ADDRESS (If rural, give location) 109 E. Glenbrook Road

3. NAME OF DECEASED (Type or Print): (First) ANNIE (Middle) AUSTIN (Last) GRIFFIN

4. DATE OF DEATH: (Month) FEB. (Day) 26 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify)

8. DATE OF BIRTH: MARCH 14, 1903

9. AGE last birthday: 45 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stenographer

10b. KIND OF BUSINESS OR INDUSTRY: Govt. Printing Office

11. BIRTHPLACE (State or foreign country): Montgomery Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSHUA THOMAS AUSTIN

14. MOTHER'S MAIDEN NAME: MARTHA ELIZABETH TALBOTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Husband

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Cardiac decompensation	one hour
Antecedent cause(s)	(b) Rheumatic Heart Disease	about 30 yrs
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Cerebral embolism & infarction (Aphasia)	4½ yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 30, 1930, to Feb. 26, 1949, that I last saw the deceased alive on Feb 18, 1949, and that death occurred at 3:15 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Edgar D. Griffin, M.D. | St. Elizabeths Hospital | Feb. 26, 1949

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)
3/1/49 | Mt. Zion | Bethesda Md.

DATE REC'D BY LOCAL REG. 2-28-49 | REGISTRAR'S SIGNATURE V.E. Jobes | 24. FUNERAL DIRECTOR Lemuel B. Pumphrey | ADDRESS -Bethesda, Md.

RECEIVED
MAR 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

01831

2411 N. Charles Street, Baltimore

7573
1330

CERTIFICATE OF DEATH

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural); LENGTH OF STAY (In this place) 5 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, D.C. COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN; STREET ADDRESS (If rural, give location) 717 Irving St., N.E.,Apt.#1

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Edward	GROS	February 28 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	W-US	single	7-14-21	27 yrs.	7	14		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Messenger in Government		La.	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
GROS, Edward H.	COVEL, Ethel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes	WWII		father: Mr. Edward H. Gros

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Chronic pyelonephritis	indefinite
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Anemia, secondary	"
(c) Agenesis right kidney	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 23, 1949, to Feb. 28, 1949, that I last saw the deceased alive on Feb. 28, 1949, and that death occurred at 8:25 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J. F. Berry	J. F. BERRY, Lt., JG MS USUSN	US Naval Hospital, Bethesda, Md.	2-28-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	3-3-49	Arlington National	Arlington, Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-28-49	Mary C. Patterson	W. W. CHAMBERS, 1400 CHAPIN S.T., N.W.	Wash.,D.C.

VS. A15

RECEIVED
MAR 3 1949
BUREAU V. S.
RECEIVED
3 1949
BUREAU V. S.

01832

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Montgomery County General Hospital Inc.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) R.F.D. # 2 - Spencerville

3. NAME OF DECEASED (Type or Print) (First) Stewart (Middle) (Last) Hackley

4. DATE OF DEATH (Month) February (Day) 20 (Year) 1949

5. SEX Male
6. COLOR OR RACE Colored.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married.
8. DATE OF BIRTH March 4, 1898
9. AGE last birthday 50 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Culpepper, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward Hackley
14. MOTHER'S MAIDEN NAME James Anna Robinson.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If year, give war or dates of service) World War I
16. SOCIAL SECURITY NO.
17. INFORMANT Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
812.5 Immediate cause	(a) Shock due to rupture of liver and	13 hrs
Antecedent cause(s)	rt. lung hemorrhage	
170 c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Fracture of 2nd-3rd & 4th ribs (rt.)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fracture of rt forearm

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road.
(CITY OR TOWN) Browns Corner, (COUNTY) Montgomery Co. (STATE) Md.
TIME OF INJURY (Month) Feb. (Day) 19, (Year) 1949 (Hour) 7:00 p.m.
INJURY OCCURRED While at Work ☐ Not While At work ☒
HOW DID INJURY OCCUR? Hit by Car.

22. I hereby certify that I attended the deceased from Dep Med Exam case, 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 8:18 A.m., from the causes and on the date stated above.

SIGNATURE Frank J. Brosshart M.D. (Degree or title) Dep Med Exam
ADDRESS Gaithersburg, Md
DATE SIGNED 2/20/49

23. BURIAL, CREMATION REMOVAL (Specify)
DATE 2/24/49
NAME OF CEMETERY OR CREMATORY Arlington
LOCATION (City, town, or county) Arlington, Va (State)

DATE REC'D BY LOCAL REG. 2-22-49
REGISTRAR'S SIGNATURE Gertrude B Fowler
24. FUNERAL DIRECTOR Robert L Snowden, ADDRESS Rockville Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
MAR 12 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 331

01833

CERTIFICATE OF DEATH 830a

Reg. Dist. No. 218

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg Md
LENGTH OF STAY (in this place) 40 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg Montgomery Co Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) OLLIE (Middle) L (Last) HEIM

4. DATE OF DEATH (Month) FEB (Day) 3 (Year) 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Aug 7-1884

9. AGE last birthday 64 yrs.

If under 1 year: Months | Days 2 | Hours | If under 24 hrs.: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Montgomery Co Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Rielder Snyder

14. MOTHER'S MAIDEN NAME Harriett Ann Pool

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Millard E Heim

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Vascular Hemorrhage	10 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis, gen'l.	Undet.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 3, 1949, to Feb. 4, 1949, that I last saw the deceased alive on Feb. 4, 1949, and that death occurred at 6 10 p.m., from the causes and on the date stated above.

SIGNATURE Jack Schumacher (Degree or title) M.D. ADDRESS Laytonsville, Md. DATE SIGNED Feb. 7, 1949.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE Feb 8-1949 | NAME OF CEMETERY OR CREMATORY Forest Oak | LOCATION (City, town, or county) Gaithersburg (State) Md

DATE REC'D BY LOCAL REG. Feb. 8, 1949 | REGISTRAR'S SIGNATURE Amelia L. Cooke | 24. FUNERAL DIRECTOR Roy W. Barber ADDRESS Laytonsville Md

RECEIVED
FEB 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

290.0 73a 01834

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH
COUNTY Montgomery County
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park. | LENGTH OF STAY (in this place) 2yrs. 5mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS George Convalescent Home. 100 Baltimore Ave.
MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural give location) 415 Wisconsin Ave NW ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
CATHERINE	TERESA	HIGGINS	FEB.	24	1949

5. SEX	6. COLOR OR RACE	7. ~~SINGLE, MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White		May 15 1874	75 yrs.	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Chevy Chase, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Patrick Welch	Honora ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
No.	none	Mrs. George 100 Baltimore Ave. Takoma Park.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Myocardial failure	48 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Pernicious Anemia.	8-10 years.
(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 1-23, 1947, to 2-24, 1949, that I last saw the deceased alive on 1-22, 1949, and that death occurred at 10 A.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
G. B. Queen M.D.		112 Willow Ave Takoma Park. Md	2-24-49.

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	2/28/49	Mt Olivet	Washington D.C.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
FEB 24 1949	J. Wilson Dodd	Robt. C. Pumphrey	7557 Wisconsin Ave. Bethesda, Md.

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

RECEIVED
FEB 26 1949
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 421.1

01835

CERTIFICATE OF DEATH 92a

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda | LENGTH OF STAY (In this place) 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D.C. — COUNTY D.C.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural give location) 505 3rd Street SE

3. NAME OF DECEASED (Type or Print): (First) Herman (Middle) Roy (Last) HOFFMAN

4. DATE OF DEATH: (Month) 2 (Day) 13 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 4-12-82

9. AGE last birthday: 66 yrs. If under 1 year: Months 10 Days 1 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Music Teacher

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): California

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Herman Hoffman

14. MOTHER'S MAIDEN NAME: Nettie Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If year, give war or dates of service): Ret-USN WWII

16. SOCIAL SECURITY NO.:

17. INFORMANT: wife: Mrs. Rose E. Hoffman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Congestion, Lung, Acute # 1805 — 2 mos.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Valvular Heart Disease — 2 yrs.

(c) Aortic Stenosis #242

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 1, 1949, to Feb. 13, 1949, that I last saw the deceased alive on 13 Feb., 1949, and that death occurred at 3:15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John W. Flynn — John W. FLYNN, Lt JG MC USN, US Naval Hospital, Bethesda, Md. — 2-13-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 2-16-49 | NAME OF CEMETERY OR CREMATORY: Arlington National | LOCATION (City, town, or county) (State): Arlington, Va

DATE REC'D BY LOCAL REG.: 2-13-49 | REGISTRAR'S SIGNATURE: Mary C. Patterson | 24. FUNERAL DIRECTOR: LEE Funeral Home | ADDRESS: 4th & Mass. Ave NE, Wash, D.

WAG

RECEIVED
FEB 17 1949
BUREAU V. S.

01836

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

332

CERTIFICATE OF DEATH

83b

Reg. Dist. No. 2235

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 203 Hancock Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Monty
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
STREET ADDRESS (If rural give location) 203 Hancock Ave

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Minnie Barnes Hortenstine

4. DATE OF DEATH (Month) Feb (Day) 25 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH 11/20/1871
9. AGE last birthday 77 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME no record
14. MOTHER'S MAIDEN NAME no record.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Mary Virginia Hortenstine

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral embolism — 30 min.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dep Med Exam case, 19..., that I last saw the deceased alive on ....., 19....., and that death occurred at 1:10 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Frank J. Brosshart M.D. Dep Med Exam
ADDRESS Gaithersburg Md
DATE SIGNED 2-25-49

23. BURIAL, CREMATION REMOVAL (Specify) DATE Feb 28
NAME OF CEMETERY OR CREMATORY Abbington Va
LOCATION (City, town, or county) Abbington Va (State)

DATE REC'D BY LOCAL REG. 2/25/49
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Deal Funeral Home
ADDRESS 4812 Ga Ave N.W. Wash D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

01837

2411 N. Charles Street, Baltimore 422.1

CERTIFICATE OF DEATH 93d

Reg. Dist. No. 211

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Purdum Md
MARYLAND
LENGTH OF STAY (in this place) 8 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland
COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Purdum Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) ROSA (Middle) E (Last) HURLEY

4. DATE OF DEATH: (Month) FEB. (Day) 11 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: NOV 23-1860

9. AGE last birthday: 88 yrs. If under 1 year: Months. 2 Days 19 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DOMESTIC

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: THOMAS E BROWN

14. MOTHER'S MAIDEN NAME: CATHERINE MOXLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: MRS. D. P DARNE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerotic cardiovascular disease — Interval Between Onset and Death: 15 years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 3, 1943, to February 11, 1949, that I last saw the deceased alive on February 11, 1949, and that death occurred at 9:00 P. m., from the causes and on the date stated above.

SIGNATURE James D. Kerr (Degree or title) M.D. ADDRESS Damascus, Md. DATE SIGNED 7 February 17, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | DATE 1949 FEB. 14 | NAME OF CEMETERY OR CREMATORY: MOUNTAIN VIEW MD | LOCATION (City, town, or county) (State): PURDUM MD

DATE REC'D BY LOCAL REG.: Feb. 14, 1949 | REGISTRAR'S SIGNATURE: Della N. Burdette | **24. FUNERAL DIRECTOR** ADDRESS: Roy W. BARBER. LAYTONSVILLE MD

RECEIVED
FEB 16 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

442 01838

CERTIFICATE OF DEATH

131a Reg. Dist. No. 215

1. PLACE OF DEATH · COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Montg
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural) — LENGTH OF STAY (in this place) 19 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Seneca
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Clint (Middle) (Last) JACKSON			4. DATE OF DEATH (Month) (Day) (Year) February 24 1949		
5. SEX male	6. COLOR OR RACE Col	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 3-30-04	9. AGE last birthday 44 yrs.	If under 1 year Months 10 Days 24 — If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME JACKSON, Basil			14. MOTHER'S MAIDEN NAME MILLS, Estelle		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY No.	17. INFORMANT daughter: Miss Blanch Jackson		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral hemorrhage, rt basal ganglia — 1 month

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension & Cerebral Arteriosclerosis — Unknown

(c) Arteriolar Nephrosclerosis — Unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☑ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Feb. 5, 1949, to Feb. 24, 1949, that I last saw the deceased alive on Feb. 24, 1949, and that death occurred at 11:20 P.m., from the causes and on the date stated above.

SIGNATURE J. H. Young (Degree or title) ADDRESS DATE SIGNED

J. H. YOUNG, Lt. JG MC USN, US Naval Hospital, Bethesda, Md. 2-26-49

23. BURIAL, CREMATION REMOVAL (Specify) burial	DATE THEREOF 3-2-49	NAME OF CEMETERY OR CREMATORY Arlington National	LOCATION (City, town, or county) (State) Arlington, Va.
DATE REC'D BY LOCAL REG. 2-26-49	REGISTRAR'S SIGNATURE Mary C. Patterson Mary C. Patterson	24. FUNERAL DIRECTOR W. E. Lewis Co. E. 4th 1432 Ten Stone	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

401.0 90b 01839

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH · COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda — LENGTH OF STAY (in this place) 17 days 4 hrs 15 min.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital	STREET ADDRESS (If rural give location) Route # 3

3. NAME OF DECEASED (Type or Print) (First) Lucy (Middle) M (Last) Jones				4. DATE OF DEATH (Month) 2 (Day) 27 (Year) 1949		
5. SEX F	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Mar. 5th 1894	9. AGE last birthday 51 yrs.	If under 1 year Months / Days 21	If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Culpeper, Va.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Alfred Carrico			14. MOTHER'S MAIDEN NAME Anna Byron			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Congestive Heart Failure — 3 weeks

Antecedent cause(s) (b) Acute Pericarditis — 6 weeks

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☒	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 25 Jan, 1949, to 27 Feb, 1949, that I last saw the deceased alive on 26 Feb, 1949, and that death occurred at 12:15 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W S Murphy	MD	Rockville Md	27 Feb 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Mar 1 1949	NAME OF CEMETERY OR CREMATORY Washington National	LOCATION (City, town, or county) (State) Suitland Md
DATE REC'D BY LOCAL REG. 2-28-49	REGISTRAR'S SIGNATURE W. E. Jobes	24. FUNERAL DIRECTOR W W Chambers Co 517 11th St SE Wash DC	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 2 1949
BUREAU U. S.

01840

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 410

CERTIFICATE OF DEATH 92b

Reg. Dist. No. 217

1. PLACE OF DEATH: COUNTY MONTGOMERY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN OLNEY
LENGTH OF STAY (in this place) 46 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS MONTGOMERY CO. GEN. HOSPITAL OLNEY, MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) R#1.

3. NAME OF DECEASED (Type or Print) (First) MICHAEL (Middle) J (Last) KELLY
4. DATE OF DEATH (Month) FEB (Day) 2 (Year) 1949
5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE
8. DATE OF BIRTH OCT 17, 1877
9. AGE last birthday 71 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BLACKSMITH
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.
12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME MICHAEL KELLY
14. MOTHER'S MAIDEN NAME MARY McGRATH
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT PATIENT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) CARDIAC INSUFFIENCY	6 years
Antecedent cause(s)	(b) RHEUMATIC HEART DISEASE	? YEARS
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) MITRAL STENOSIS + INSUFFICIENCY	? YEARS

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from DEC 17, 1948, to FEB 2, 1949, that I last saw the deceased alive on FEB 2, 1949, and that death occurred at 8 17 A m., from the causes and on the date stated above.

SIGNATURE Robert R. Williams (Degree or title) M.D. ADDRESS Montgomery County General Hospital Olney, Maryland. DATE SIGNED 2-2-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Feb 4, 1949
NAME OF CEMETERY OR CREMATORY Wilington National
LOCATION (City, town, or county) Virginia (State)
DATE REC'D BY LOCAL REG. Feb 2
REGISTRAR'S SIGNATURE Gertrude B Fawler
24. FUNERAL DIRECTOR Warren E Pamphrey, Inc. ADDRESS Silver Spring, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 16 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

01841

2411 N. Charles Street, Baltimore 331

CERTIFICATE OF DEATH 830

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural)
LENGTH OF STAY (In this place) ½ hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arlington
STREET ADDRESS (If rural, give location) 1230 So. Arlington Ridge Road ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Benjamin	Stacy	KILLMASTER	February 6 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	W-US	married	6-7-93	55 yrs.	7	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Navy		Michigan	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
KILLMASTER, Charles D.	DUNCAN, Ellen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes	WWI WWII		wife: Mrs. Dorothy C. Killmaster

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 7 hrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feb. 6, 1949, to Feb. 6, 1949, that I last saw the deceased alive on Feb. 6, 1949, and that death occurred at 7 P.M. 11:38 P.m., from the causes and on the date stated above.

SIGNATURE W. E. Lowery (Degree or title) ADDRESS DATE SIGNED

W. E. LOWERY, Lt JG MC USN, U. S. NAVAL HOSPITAL, Bethesda, Md. 2-6-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	2-9-49	Arlington National	Arlington, Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-6-49	Mary C. Patterson Mary C. Patterson	Joseph Gawler, 1736 Pennsylvania Ave. Wash., D.C.	SE 84 #304

RECEIVED
FEB 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 420.1 94a 01842

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural)
LENGTH OF STAY (in this place): 1 mon. 26 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: North Carolina — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Camp Lejeune
STREET ADDRESS (If rural give location): Quarters 3138 ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ira	Lafayette	KIMES	February 4 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	W-US	married	8-8-99	49 yrs.	5	26		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Marine Corps		Tenn.	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
KIMES, Utie	EDDINS, Susan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
yes	WW I		wife: Mrs. Norina B. Kimes

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary insufficiency & failure	immediate
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary arteriosclerosis, marked	4-5 years
	(c) Myocardial infarction — two times	1944 & 1948

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec. 6, 1948, to Feb. 4, 1949, that I last saw the deceased alive on Feb. 4, 1949, and that death occurred at 07:15 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
L. J. POPE	Cdr. MC USN	US Naval Hospital, Bethesda, Md.	2-4-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	2-8-49	Arlington National	Arlington, Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3-4-49	Mary C. Patterson	W. W. Chambers Co.	3072 M. St. N.W.

W. W. CHAMBERS, 3072 M St., N.W., Wash., DC

VS. A15

RECEIVED
FEB 8 1949
BUREAU V. S.

EVIDENCE FOR RENUMBERING IN # 18 IS ON!

FILM No. G 119 MAR 28 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

442 01843

CERTIFICATE OF DEATH

13/a Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) 1 mo 3 wks 3 da
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sam + Hosp. Carroll Ave Takoma Park, Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Dist. of Col COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural give location) 1340 Gallatin St N.W.

3. NAME OF DECEASED (Type or Print) (First) Louise (Middle) Burke (Last) Kirby

4. DATE OF DEATH (Month) (Day) (Year) 2 - 13 - 49 19

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH 3-3-84
9. AGE last birthday 64 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary (retired)
10b. KIND OF BUSINESS OR INDUSTRY Maratime comm
11. BIRTHPLACE (State or foreign country) New York NY.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Oscar P. Kirby
14. MOTHER'S MAIDEN NAME Esther Hazen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT pts chart

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (c) ~~(a)~~ Malignant Hypertensive Cardiovascular Renal Disease — 6 mos

Antecedent cause(s) (a) ~~(b)~~ Uremia and Retinopathy — 2 wks

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ~~(c)~~ Uremic Pericarditis (3/28/49 abc)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-17, 1948, to 2-13, 1949, that I last saw the deceased alive on 2-13, 1949, and that death occurred at 4:15 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
DeFoe K. Meade M.D. 504 Tulip Ave. Takoma Park 12, Md 2-13-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 2-15-1949
NAME OF CEMETERY OR CREMATORY State Hill Cemetery
LOCATION (City, town, or county) (State) Kirbytown, N.J.
DATE REC'D BY LOCAL REG. 2/13/49
REGISTRAR'S SIGNATURE J. Milton Dodd
24. FUNERAL DIRECTOR ADDRESS S. H. Hines Co., Washington, D.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
FEB 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

EVIDENCE FOR CHANGE OF SPELLING SHOWN ON FILM No. G 11 7 FEB 24 1949

163 472

01844

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
LENGTH OF STAY (in this place): 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: USNHospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Virginia — COUNTY: Prince Wm.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ~~Dunnfiece~~ Dumfries
STREET ADDRESS (If rural give location): Star Route

3. NAME OF DECEASED (Type or Print): (First) Paul (Middle) (n) (Kirchhefer) (Last) KIRCHEFER

4. DATE OF DEATH: (Month) 2 (Day) 13 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 2-26-95

9. AGE last birthday: 53 yrs. If under 1 year: Months 11 Days 17 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): USMC RETINACT

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Recent Kirchhefer

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If year, give war or dates of service): WWII

16. SOCIAL SECURITY No.:

17. INFORMANT: wife: Mrs. Helen C. Kirchefer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Metastatic lesion of brain

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Malignancy of lung

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 7, 1949, to Feb. 13, 1949, that I last saw the deceased alive on Feb. 13, 1949, and that death occurred at 2:40 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

J. C. McNerney J. C. McNERNEY, Cdr. MC USN US Naval Hospital, Bethesda, Md. 2-13-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 2-15-49 — NAME OF CEMETERY OR CREMATORY: Arlington National — LOCATION (City, town, or county) (State): Arlington, Va.

DATE REC'D BY LOCAL REG. 2-13-49

REGISTRAR'S SIGNATURE: Mary C. Patterson Mary C. Patterson

24. FUNERAL DIRECTOR — ADDRESS: Hall Funeral Home Occoquan, Va.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

491

01845

CERTIFICATE OF DEATH

107

Reg. Dist. No. 213

1. PLACE OF DEATH · COUNTY: Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville — LENGTH OF STAY (in this place): 1-Mon.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: $00 Rockville
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Own Home	STREET ADDRESS (If rural give location): 406 Blandford Ave.

3. NAME OF DECEASED (Type or Print)	(First) Judith	(Middle) Terry	(Last) Lacey	4. DATE OF DEATH	(Month) Feb. (Day) 5, (Year) 1949
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: March 22, 1948	9. AGE last birthday: yrs.	If under 1 year: Months 10 Days 13; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant	10b. KIND OF BUSINESS OR INDUSTRY: -------	11. BIRTHPLACE (State or foreign country): Harlan, Kentucky	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Leonard B. Lacey	14. MOTHER'S MAIDEN NAME: Jewell Noe				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Leonard B. Lacey (father)			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Broncho-pneumonia — 3 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Mongolism

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 8, 1949, to Feb 4, 1949, that I last saw the deceased alive on Feb 4, 1949, and that death occurred at 5 A.M. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm. F. Burdick	M.D. 2721	Conn Ave N.W. Wash D.C.	3/5/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Feb. 7, 1949	NAME OF CEMETERY OR CREMATORY: Resthaven	LOCATION (City, town, or county) (State): Harlan, Kentucky
DATE REC'D BY LOCAL REG.: 2-6-49	REGISTRAR'S SIGNATURE: E P Thompson	24. FUNERAL DIRECTOR: Robert A. Pumphrey	ADDRESS: Bethesda, Md.

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BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 213

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH · COUNTY: Montgomery · STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland · COUNTY: Montg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville · LENGTH OF STAY (in this place): 28 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Rockville Pike	STREET ADDRESS (If rural give location): Rockville Pike

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Archibald	MacMillan	Lake	Feb	23	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	White	Widowed	May 22 1879	69 yrs.	9	1		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Contractor		Washington, D.C.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Lake	Elizabeth F. Betzel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	None	Jack Lake

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	2/22/49
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Nephritis	to 2/23/49
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/17/48, 19..., to 2/23, 19..., that I last saw the deceased alive on Feb 23, 1949, and that death occurred at 5:10 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C E Hawks	M.D.	Rockville Md	2/24/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb 26/49	Rockville Union	Rockville, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/25/49	D P Thompson	Robert L. Pumphrey	Bethesda, Md.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

180 01847

CERTIFICATE OF DEATH 52a

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Montgomery; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural); LENGTH OF STAY (in this place): 1yr 3 mons. 18 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Washington, D. C. COUNTY: CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: STREET ADDRESS (If rural give location): 912 K St., N.E.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Albert		LAUCK, Jr.		February	16	1949

6. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	W-US	married	9-3-91	57 yrs.	6	14		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Printer	US Government	Washington, D.C.	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
LAUCK, Albert	REGAN, Catherine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes	WWI		wife: Mrs. Catherine Lauck

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Recurrent Hypernephroma right	5 yrs.,
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Obstruction inferior vena Cava	
	(c) Bronchopneumonia	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 28 Nov., 1947, to Feb. 16, 1949, that I last saw the deceased alive on Feb. 16, 1949, and that death occurred at 11:15 Pm., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
James F. Berry James F. BERRY, Lt JG MC USN	US Naval Hospital, Bethesda, Md.	2-16-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	2-21-49	Arlington National	Arlington, Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
2-17-49	Mary C. Patterson	Frank Geier, & Sons, 3605 14th St., N.W. Wash., D.C.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

177 01848

CERTIFICATE OF DEATH 51b

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: MONTGOMERY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BETHESDA (rural)
LENGTH OF STAY (in this place): 1 mon.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: VIRGINIA — COUNTY: ARLINGTON
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural give location): 912 So. Veitch Street ✓

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) EDWARD (Last) LIGHTFOOT

4. DATE OF DEATH: (Month) February (Day) 19 (Year) 1949

5. SEX: male

6. COLOR OR RACE: W-US

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: 2-20-63

9. AGE last birthday: 85 yrs. If under 1 year: Months 11 Days 29 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Taylor

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Army

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: LIGHTFOOT, Edward

14. MOTHER'S MAIDEN NAME: EASTMAN, Emma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If year, give war or dates of service): Indian Campaign

16. SOCIAL SECURITY NO.:

17. INFORMANT: son: Mr. Charles E. Lightfoot

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a): Cystitis, Necrotic, purulent with cerebral obstruction and supra pubic abscess

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): Carcinoma of Prostate

(c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 19, 1949, to Feb. 19, 1949, that I last saw the deceased alive on Feb. 19, 1949, and that death occurred at 12:55P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wm. T. Miller, Lt. MC USN, US Naval Hospital, Bethesda, Md. 2-20-49

23. BURIAL, CREMATION, REMOVAL (Specify): burial
DATE: 2-22-49
NAME OF CEMETERY OR CREMATORY: Columbia Gardens
LOCATION (City, town, or county) (State): Arlington, Va.

DATE REC'D BY LOCAL REG. 2-20-49
REGISTRAR'S SIGNATURE: Mary C. Patterson

24. FUNERAL DIRECTOR: IVES FUNERAL HOME
ADDRESS: ARLINGTON, VA.

Ives Funeral Home
per W.R.W. Jr.

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

57e Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase — LENGTH OF STAY (in this place) 10 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase M.D.
~~HOSPITAL OR INSTITUTION OR~~ STREET ADDRESS 6520 Western ave	STREET ADDRESS (If rural, give location) 6420 Western ave

3. NAME OF DECEASED (Type or Print) (First) JULIUS (Middle) C (Last) MARTIN			4. DATE OF DEATH (Month) Feb (Day) 9 (Year) 1949		
5. SEX male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Oct 2. 1861	9. AGE last birthday 87 yrs.	If under 1 year Months 4 Hrs. Days 7 days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wilkes Co N.C.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME AUGUSTA H MARTIN			14. MOTHER'S MAIDEN NAME unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Norman Martin		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Tumor of liver, type and origin undetermined.	6 months
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arterio sclerosis, generalized with particular involvement of coronary arteries and congestive heart failure. 9 months.

19a. DATE OF OPERATION NONE	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 4, 1948, to Feb. 9, 1949, that I last saw the deceased alive on Feb. 8, 1949, and that death occurred at 6:00 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Thomas A. Wildman, M.D.		Washington DC.	Feb. 9, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 12, 1949	Rock Creek Cemetery	Washington DC

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 9, 1949	Josephine M Schaeffer	The S. H. Hines Co	2901. 14th Mod Wash DC

3731 Morrison, N.W.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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FEB 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 903.0 01850

CERTIFICATE OF DEATH 1860

Reg. Dist. No. 2 17

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney; LENGTH OF STAY (in this place) 14 hours; HOSPITAL OR INSTITUTION OR STREET ADDRESS The Montgomery County General Hospital Inc.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Frederick; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick; STREET ADDRESS (If rural, give location) 109 W. Patrick ST.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) H. (Last) McCaffrey

4. DATE OF DEATH: (Month) February (Day) 3 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White.

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: August 20, 1861

9. AGE last birthday: 87 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Sharpsburg, Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Nathan Heiberger

14. MOTHER'S MAIDEN NAME: Elizabeth Agnes Webb.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. William A. Marrow-

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Embolism	1 day
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Fracture of femur - right	1 day
	(c) Chronic arteriosclerosis	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify): accident

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Nursing home

(CITY OR TOWN) (COUNTY) (STATE): Silver Spring, R. 7, D. Mont. C., Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): Feb. 2, 1949, 9 p.m.

INJURY OCCURRED While at Work ☐ Not While At work ☑

HOW DID INJURY OCCUR? Fall to floor.

22. I hereby certify that I attended the deceased from ~~Medical Examiner's Case~~, 19..., to ~~Medical Examiner's Case~~, 19..., ~~that I last saw the deceased~~ alive on ..., 19..., and that death occurred at 10:40 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Emil F. Bauersfeld, M.D. Asst. Dept. Med. Examiner Bethesda, Md. Montgomery Co. 2-3-49

23. BURIAL, CREMATION, REMOVAL (Specify): DATE 2-6-49; NAME OF CEMETERY OR CREMATORY St. Johns; LOCATION (City, town, or county) Frederick (State) Md.

DATE REC'D BY LOCAL REG. Feb 3 49; REGISTRAR'S SIGNATURE Gertrude B Fawler

24. FUNERAL DIRECTOR: Hamm & Fiery ADDRESS Frederick Md

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FEB 16 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

97 Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN White Oak
LENGTH OF STAY (in this place) 56 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN White Oak
STREET ADDRESS (If rural, give location) Silver Spring

3. NAME OF DECEASED (Type or Print) (First) ANNA (Middle) BARNITZ (Last) McCENEY

4. DATE OF DEATH (Month) FEB. (Day) 19, (Year) 1949

5. SEX F

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH MAY 22, 1862.

9. AGE last birthday 86 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME McPherson Barnitz

14. MOTHER'S MAIDEN NAME Augusta Harrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If year, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT Wm. H. McCeney, Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Senility

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: about 5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized atherosclerosis

?

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from ....., 1946, to 19 Feb, 1949, that I last saw the deceased alive on 14 Feb, 1949 and that death occurred at 4 P m., from the causes and on the date stated above.

SIGNATURE William D. Aud, MD (Degree or title) ADDRESS 9006 Colesville Rd Silver Spring DATE SIGNED 19 Feb 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Feb 22, 1949

NAME OF CEMETERY OR CREMATORY St Marks Church Cemetery

LOCATION (City, town, or county) Fairland, Montg. Co. (State) Md.

DATE REC'D BY LOCAL REG. Feb. 19, 1949

REGISTRAR'S SIGNATURE Josephine M. Schaeffe

24. FUNERAL DIRECTOR Arthur J. Walters ADDRESS 254 Carroll St Takoma Park, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

M

I

OF 19

RECEIVED
FEB 25 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

443 01852

CERTIFICATE OF DEATH 93d

Reg. Dist. No. 714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery County — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
LENGTH OF STAY (in this place): 5 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Cedarcroft Sanitarium

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Washington, D. C. — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Washington, D. C.
STREET ADDRESS (If rural, give location): 306 2nd Street S.E. ✓

3. NAME OF DECEASED (Type or Print): (First) Rosalie (Middle) (Last) McGrath

4. DATE OF DEATH: (Month) February (Day) 18 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: May 19, 1889

9. AGE last birthday: 59 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ret. yeomanette

10b. KIND OF BUSINESS OR INDUSTRY: Navy

11. BIRTHPLACE (State or foreign country): Columbus, Ohio

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: James McGrath

14. MOTHER'S MAIDEN NAME: Mary Touhy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): yes

16. SOCIAL SECURITY NO.:

17. INFORMANT: sister: Mrs. Anna Washburn

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Myocarditis — ?

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ~~Hypertension~~ — ?

(c) Gen. Arteriosclerosis — ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/18/48, 19..., to 2/18, 19.49, that I last saw the deceased alive on 2/18, 19.49, and that death occurred at 12:30 Am., from the causes and on the date stated above.

SIGNATURE: W. B. Thiladeau M.D. (Degree or title) Med. Director — ADDRESS: Cedarcroft Sanitarium Silver Spring, Md — DATE SIGNED: February 18, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 2/23/49 — NAME OF CEMETERY OR CREMATORY: Arlington — LOCATION (City, town, or county) (State): Arlington Va.

DATE REC'D BY LOCAL REG.: Feb. 18. 1949 — REGISTRAR'S SIGNATURE: Josephine M. Schaeffer

24. FUNERAL DIRECTOR: Jas. J. Ryan — ADDRESS: 317 8th Ave. Wash. D. C.

RECEIVED
FEB 21 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

692.6
135a

01853

Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington San. & Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Dist. of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wash. D.C.
STREET ADDRESS (If rural give location) 6728 2nd St. N.W. ✓

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Meikeljohn (Last)

4. DATE OF DEATH (Month) 2 (Day) 21 (Year) 1949

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed
8. DATE OF BIRTH 7/14/67
9. AGE last birthday 81 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY fuel business
11. BIRTHPLACE (State or foreign country) Scotland
12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME William Meiklejohn
14. MOTHER'S MAIDEN NAME Jean Barrie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT family

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Congestive Cardiac Failure	? hours.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cellulitis	10 days.
	(c) (Cystitis)	10 mos.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Feb. 13 '49
19b. MAJOR FINDINGS OF OPERATION Extravasation of Urine
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1944, to Feb 21, 1949, that I last saw the deceased alive on Feb 21, 1949, and that death occurred at 10:30P m., from the causes and on the date stated above.

SIGNATURE Robert A. Hare MD. (Degree or title) ADDRESS Takoma Park. Md. DATE SIGNED 2/21/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Feb 24, 1949.
NAME OF CEMETERY OR CREMATORY Rock Creek
LOCATION (City, town, or county) Washington (State) D.C.

DATE REC'D BY LOCAL REG. 2/22/49
REGISTRAR'S SIGNATURE J. Hilton Dodd
24. FUNERAL DIRECTOR Arthur S. Walters ADDRESS 254 Carroll St. N.W. Takoma Park, D.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS. A15

RECEIVED
FEB 23 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

443 01854

CERTIFICATE OF DEATH

932 Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery County
City or town: Gaithersburg —
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg —
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4602 - Bayard Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: IDA KERBER MILLER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: HENRY V. MILLER
6.(c) If alive, give age: Deceased years

7. Birth date of deceased (mo., day, yr.): Nov. 8, 1867

8. AGE:

Years	Months	Days	If less than one day
81	2	20	hrs. min.

9. Birthplace: New York, N.Y. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Joseph Kerber
13. Birthplace: Germany

MOTHER
14. Maiden name: Walberga Raible
15. Birthplace: Germany

16. Informant: John V. Miller
Address: 4602 - Bayard Blvd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 6 1949 (month) (day) (year)
Cemetery or crematory: St Mary's Cemetery
Location: Hyatt. D. C.

18. Funeral director: W. Don. DeVol
Address: 2224 - Wis. Ave

19. 2-6-49 (Date rec'd by registrar) 19 WEJobe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 5. 1949 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 18. 1948 to Feb 5. 1949 and that I last saw h[er] alive on Feb 5. 1949

Immediate cause of death	DURATION
Hypertensive heart disease	10-12yr.
Due to: Uremia.	6 wk.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C P Ryland M.D. M. D. or other
Address: 4901 Massachusetts NW. Work Washington D.C. Date signed: 2-6-49

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

RECEIVED
FEB 9 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 410.0 472 01855

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural)
LENGTH OF STAY (in this place) 1 mon. 39 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. NAVAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, D. C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) 321 Crittened St., N. W.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Joseph (Last) MORIARTY
4. DATE OF DEATH: (Month) February (Day) 24 (Year) 1949

5. SEX: male
6. COLOR OR RACE: W-US
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 4-9-92
9. AGE last birthday: 56 yrs. If under 1 year: Months 10 Days 15 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Civil Service
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: MORIARTY, John
14. MOTHER'S MAIDEN NAME: HOGAN, Julia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If year, give war or dates of service): WWI
16. SOCIAL SECURITY NO.
17. INFORMANT: wife: Mrs. Helen Moriarty

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Valvular Heart Disease (Mitral Stenosis)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma (small cell) Right Lung - metastic

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 15, 1948, to Feb. 24, 1949, that I last saw the deceased alive on Feb. 24, 1949, and that death occurred at 1:30 P m., from the causes and on the date stated above.

SIGNATURE D. E. Billman Jr. (Degree or title) ADDRESS DATE SIGNED

D. E. BILLMAN, Lt JG MC USN, US Naval Hospital, Bethesda, Md. 2-24-49

23. BURIAL, CREMATION REMOVAL (Specify): burial
DATE: 3-1-49
NAME OF CEMETERY OR CREMATORY: Arlington National
LOCATION (City, town, or county) (State): Arlington, Va.

DATE REC'D BY LOCAL REG. 2-24-49
REGISTRAR'S SIGNATURE Mary C. Patterson
24. FUNERAL DIRECTOR ADDRESS: Hysong Funeral Home, 1900 N St., N.W. Wash., D.C.

RECEIVED
FEB 26 1949
BUREAU V. S.

RECEIVED
1949
BUREAU V. S.

Evidence for change of birth date is on: Film No. G119, Feb. 18, 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01856

H20.1

CERTIFICATE OF DEATH 94a

Reg. Dist. No. 216

M

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda; STREET ADDRESS (If rural, give location) 7134 Bradley Lane

3. NAME OF DECEASED (Type or Print)	(First) Samuel	(Middle) Richard	(Last) Newlon	4. DATE OF DEATH	(Month) Feb.	(Day) 13	-	(Year) 1949	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH Sept. 20 - 1858	9. AGE last birthday 90 yrs.	If under 1 year Months 3	Days 24	If under 24 hrs. Hours	Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS, OR INDUSTRY Retired Real Estate	11. BIRTHPLACE (State or foreign country) London Co. Va	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Alfred Newlon		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Roger B. Smith	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 25, 1949, to Feb 13, 1949, that I last saw the deceased alive on Feb 13, 1949, and that death occurred at 4:25 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Emil G. Bauerfeind	M.D.	Bethesda, Md	2-13-49.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb. 15-49	Lewinsville	Fairfax Co.	Va

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-13-49	W. E. Jobes	C. J. Ches	2847 Wilson Blvd. Arlington Va

RECEIVED
FEB 15 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01857

177

CERTIFICATE OF DEATH 516

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY Montgomery Co., MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Md.
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE COUNTY Mont
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mrs Relda Havener Dickerson Maryland
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Mr (Middle) Thomas N. (Last) Newton

4. DATE OF DEATH (Month) 2-26 (Day) (Year) 1949

5. SEX M

6. COLOR OR RACE Wh

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W.

8. DATE OF BIRTH May 7, 1859

9. AGE last birthday 89 yrs. If under 1 year Months 9 Days 17 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Louden Co. Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A. N. Amer. C A

13. FATHER'S NAME Charles Newton

14. MOTHER'S MAIDEN NAME Mary Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of the Prostate

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) with metastases

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Healed Pulmonary Tuberculosis

19a. DATE OF OPERATION 11-22-48

19b. MAJOR FINDINGS OF OPERATION Carcinoma of the Prostate

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-25, 1948, to 2-26, 1949, that I last saw the deceased alive on 2-26, 1949, and that death occurred at 6:35 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) James E. Boyland, M.D. ADDRESS Suburban Hospital DATE SIGNED 2-26-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE 3/1/49 NAME OF CEMETERY OR CREMATORY Monocacy LOCATION (City, town, or county) (State) Beallsville Md.

DATE REC'D BY LOCAL REG. 2/28/49 REGISTRAR'S SIGNATURE W.E. Jobes

24. FUNERAL DIRECTOR Wm. B. Hilton ADDRESS Barnesville Md.

RECEIVED
MAR 4 1949
BUREAU V. S.

01888

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

162

CERTIFICATE OF DEATH 47c

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural) — LENGTH OF STAY (in this place): 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Mexico — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mexico City
STREET ADDRESS (If rural give location): Versalles Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Robert	Wallace	OLINGER	February	18	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	W-US	widowed	1-8-84	65 yrs.	1	10		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreign Petroleum Specialist
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: OLINGER, John W.
14. MOTHER'S MAIDEN NAME: BECKWORTH, Camelia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If year, give war or dates of service): WWI
16. SOCIAL SECURITY NO.:
17. INFORMANT: son: Mr. Philip C.OLINGER

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Primary shock due to
Antecedent cause(s) procaine sensitivity
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)
(c) Bronchogenic Carcinoma

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb med Exam case 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 1:40 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Frank J. Brockhaus
Feb med Exam — Gaithersburg, Md — 2-19-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	2-24-49	Arlington National	Arlington, Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
2-19-49	Mary C. Patterson	W. W. CHAMBERS, 1100 Chapin St., N. W., Wash., D.C.

F.C.

RECEIVED
FEB 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 525

01859

CERTIFICATE OF DEATH 1142

Reg. Dist. No. 215

M

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH: COUNTY Montgomery; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural); LENGTH OF STAY (in this place) 10 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S.N. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Wash., D.C. COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN; STREET ADDRESS (If rural give location) 5608 L St., S.E.

3. NAME OF DECEASED (Type or Print): (First) Simon (Middle) (Last) Oliver Sr.

4. DATE OF DEATH: (Month) February (Day) 4 (Year) 19 49

5. SEX: male

6. COLOR OR RACE: W-US

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 4-27-91

9. AGE last birthday: 57 yrs. If under 1 year: Months 9 Days 7 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): N.C.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: OLIVER, John

14. MOTHER'S MAIDEN NAME: MEARS, KATY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If year, give war or dates of service): WWI

16. SOCIAL SECURITY NO.:

17. INFORMANT: wife: Mrs. Mary Oliver

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cor Pulmonale #2 xg	6 Mo.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Fibrosis, Pulmonary #18 xg	2 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 24, 1949, to Feb. 4, 1949, that I last saw the deceased alive on 4 Feb., 1949, and that death occurred at 8:45 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W. F. Queen

Wm. F. QUEEN, Cdr. MC USN, U. S. NAVAL HOSPITAL, Bethesda, Md. 2-5-49

23. BURIAL, CREMATION REMOVAL (Specify): Transportation

DATE: 2-5-49

NAME OF CEMETERY OR CREMATORY: National Cemetery

LOCATION (City, town, or county) (State): Wilmington, N. C.

DATE REC'D BY LOCAL REG. 2-5-49

REGISTRAR'S SIGNATURE: Mary C. Patterson

24. FUNERAL DIRECTOR: W. W. Chambers Co.

ADDRESS: 517-11-M.E.

W. W. CHAMBERS, 517 11th St., S.E. Wash., D.C.

VS. A15

RECEIVED
FEB 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 420.1 01860

CERTIFICATE OF DEATH 940 Reg. Dist. No. 2/6

M — The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville
LENGTH OF STAY (in this place): 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 919 Grandin Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville
STREET ADDRESS (If rural give location): 919 Grandin Ave

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
CLARA	E	OSMOND	Feb	11	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widow	2/5/60	89 yrs.	0	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	---	Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Dwyer	Marthie Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	Son Frank Osmond

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — Few minutes.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Asteriosclerosis — 5 years

(c) Senility —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
No.	—			

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
—	—		m.		—

22. I hereby certify that I attended the deceased from 1943 to Feb. 11, 1949 that I last saw the deceased alive on Feb. 11, 1949, and that death occurred at 8 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm. A. Linthicum	M.D.	Rockville, Md.	2/11/49.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/14/49	Rockville Union Ceme	Rockville	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-14-49	W. E. Jobe	Robert A. Dunphey	Bethesda, Md.

RECEIVED
FEB 16 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

EVIDENCE FOR ADDITIONAL INFO. # 180. IS ON:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

610 01861

FILM No. G 119 MAR 28 1949

CERTIFICATE OF DEATH 1370

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Washington, D. C. — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural) — LENGTH OF STAY (in this place): 2 mos. 19 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital	STREET ADDRESS (If rural give location): 509 E St., N. W.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William		PHELIPOW	February	2	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	W-US	single	9-15-86	62 yrs.		17		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Barber		Russia	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
PHELIPOW, Sam	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes	WWI		6500 Patterson Avenue, Richmond, Va. brother-in-law: Mr. B. Arenstein

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Traumatic ruptured urinary bladder with

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) massive intra-peritoneal hemorrhage, postoperative 6 hrs.

(c) Pulmonary Edema during irrigating a bladder after a transurethral prostatic resection (3/28/49 also)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2-2-49	Benign Prostatic Hypertrophy	Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 13 Jan., 1949, to 2 Feb., 1949, that I last saw the deceased alive on 2 Feb., 1949, and that death occurred at 2:57 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm. H. Miller Jr.	Lt MC USN	US Naval Hospital, Bethesda, Md.	2-4-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	2-8-49	Arlington National	Arlington, Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-4-49	Mary C. Patterson	W. W. CHAMBERS	1400 Chapin St., N.W. Wash., D.C.

RECEIVED
FEB 8 1949
BUREAU V. S.

17045

01862

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

331

CERTIFICATE OF DEATH

830

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
STREET ADDRESS (If rural give location) 8631 Garfield St.

3. NAME OF DECEASED (Type or Print) (First) Tobias (Middle) Porter (Last) Plummer

4. DATE OF DEATH (Month) Feb. (Day) 25, (Year) 1949.

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower
8. DATE OF BIRTH Jan. 1, 1861
9. AGE last birthday 88 yrs. If under 1 year: Months 1 Days 25 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Railroad Foreman
11. BIRTHPLACE (State or foreign country) Three Rivers, Mich.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John Plummer
14. MOTHER'S MAIDEN NAME Martha

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Esther Langford (daughter

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebro vascular accident

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 2 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT ✓ (Specify) SUICIDE HOMICIDE
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ✓ (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/23, 1949 to 2/25, 1949 that I last saw the deceased alive on 2/25, 1949, and that death occurred at 9:15 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

[signature] Cantor M.D. 2/28/49

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE 2/28/49
NAME OF CEMETERY OR CREMATORY
LOCATION (City, town, or county) (State) Mancelona, Michigan

DATE REC'D BY LOCAL REG. 2-28-49
REGISTRAR'S SIGNATURE [signature] Jobes
24. FUNERAL DIRECTOR [signature] A. Humphrey
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 3 1949
BUREAU V. S.

EVIDENCE FOR ADDITION OF #18c ISON;

FILM No. G 119 MAR 28 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01863

442

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY: Montg Co, MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gaithersburg,
LENGTH OF STAY (In this place): 11yrs 3Mo,
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Methodist Home Gaithersburg Md,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Va. COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Leesburg
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Emma (Middle) Alice (Last) Portmess

4. DATE OF DEATH: (Month) Feb (Day) 21 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: July 2-1867

9. AGE last birthday: 81yrs yrs. If under 1 year: Months. 7 Days. If under 24 hrs.: Hours. 19 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: "

11. BIRTHPLACE (State or foreign country): Williamsport Pa,

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry J. Steavey

14. MOTHER'S MAIDEN NAME: Rachiel Ridge

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.:

17. INFORMANT: Methodist Home Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) cardio - nephritis — 25 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senility — 5 years

(c) High arterial tension [2/28/49 akcc]

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan-27-, 1949, to Feb-21-, 1949, that I last saw the deceased alive on Feb-19, 1949, and that death occurred at 3 30 4 m., from the causes and on the date stated above.

SIGNATURE (Degree or title): William C Miller, M.D. ADDRESS: Gaithersburg Md DATE SIGNED: Feb. 21-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE: Feb 23rd/49 NAME OF CEMETERY OR CREMATORY: Levels Cemetery LOCATION (City, town, or county) (State): Levels W Va, (Rommey)

DATE REC'D BY LOCAL REG.: Feb 21, 1949 REGISTRAR'S SIGNATURE: Alma L. Cooke

24. FUNERAL DIRECTOR ADDRESS: Ernest C Gartner, Gaithersburg Md

VS. A15

RECEIVED
FEB 23 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

002 01864

CERTIFICATE OF DEATH 13b

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY MONTOGMERY; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda(rural); LENGTH OF STAY (in this place) 5 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cabin John; STREET ADDRESS (If rural, give location) Cabin John Post Office

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Harry	Edward	Powell	2	19	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	Colored	Single	4-7-95	53 yrs.	10	12		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Virginia	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Benjamin Powell	Martha Hollace

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
Yes WWI		brother: Mr. Homer P. Powell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Tuberculosis, Meningitis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Tuberculosis, Peritonitis

(c) Tuberculosis, Pneumonia

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feb. 14, 1949, to Feb. 19, 1949, that I last saw the deceased alive on Feb. 19, 1949, and that death occurred at 2:30 A m., from the causes and on the date stated above.

SIGNATURE R. B. Hallberg (Degree or title) R. B. HALLBORG, LCDR MC USN ADDRESS US Naval Hospital, Bethesda, Md. DATE SIGNED 2-19-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	2-25-49	Arlington National	Arlington, Virginia

DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-20-49	Mary J. Patterson	W. E. JARVIS	1432 U. St. N.W. Wash., D.C.

RECEIVED
FEB 22 1949
BUREAU V. S.

01865

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1

CERTIFICATE OF DEATH

94a Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY: Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda — LENGTH OF STAY (in this place): 12 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Home	STREET ADDRESS (If rural, give location): 8510 Salem Way

3. NAME OF DECEASED (Type or Print)	(First) JAMES	(Middle) MOFFETT	(Last) POWER	4. DATE OF DEATH	(Month) Feb. (Day) 24 (Year) 1949
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: July 3, 1881	9. AGE last birthday: 67 yrs.	If under 1 year: Months 7, Days 21; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired	10b. KIND OF BUSINESS OR INDUSTRY: Navy Yard	11. BIRTHPLACE (State or foreign country): Louden Co. Virginia	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Joseph Power		14. MOTHER'S MAIDEN NAME: Katherine Muse			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If year, give war or dates of service): Spanish American	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Gertrude L. Power (daughter)			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	died suddenly
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dep Med 19 Exam case 19, that I last saw the deceased alive on ....., 19....., and that death occurred at 10:30P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank J. Broschart M.D.	Dep Med. Exam.	Gaithersburg Md	2-25-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Feb. 28, 1949	NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery	LOCATION (City, town, or county) (State): Washington, D. C.
DATE REC'D BY LOCAL REG.: 2-28-49	REGISTRAR'S SIGNATURE: N. E. Jobes	24. FUNERAL DIRECTOR: Robert A. Lumpkey	ADDRESS: Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 3 1949
BUREAU V. S.

01866

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 218

1. PLACE OF DEATH: COUNTY Montgomery Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Germantown
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Montgomery Co. COUNTY Maryland
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Boyds
STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print) (First) James (Middle) Jackson (Last) Prather

4. DATE OF DEATH (Month) Feb. (Day) 5 (Year) 1949

5. SEX male

6. COLOR OR RACE colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH July 20 1897

9. AGE last birthday 51 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME James Jackson

14. MOTHER'S MAIDEN NAME Teresa Prather

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Gertrude Jackson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion

Antecedent cause(s) —

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

INTERVAL BETWEEN ONSET AND DEATH: 1 day

19a. DATE OF OPERATION None

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Medical Examiner's Case, 19 to 19 that I last saw the deceased alive on —, 19 , and that death occurred at 2 a. m., from the causes and on the date stated above.

SIGNATURE Emil G. Bangsfeld M.D. (Degree or title) ADDRESS Bethesda, Md DATE SIGNED 2/5/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE Feb. 9, 1949 NAME OF CEMETERY OR CREMATORY Brownstown, Md. LOCATION (City, town, or county) Germantown, Md (State)

DATE REC'D BY LOCAL REG. Feb 9, 1949 REGISTRAR'S SIGNATURE Alruda G. Cooke

24. FUNERAL DIRECTOR Robert L. Snowden, ADDRESS Rockville, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 153

01867

CERTIFICATE OF DEATH 462

Reg. Dist. No. 223-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park	LENGTH OF STAY (in this place) 20 days
	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium	STREET ADDRESS (If rural give location) 902 Jackson Ave -

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Anne	Lavene	Rasmussen	Feb.	12	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Female	Wh	Widow	5-19-88	60 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Secretary	Seventh Day Adv. Conference	Oslo, Norway	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Peter Christensen	Maria Lundius

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Washington Sanitarium Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Gen. Carcinomatosis of abdomen	6 mos
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Carcinoma of cecum	Mar 1946.
(c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on 2-12, 1949, and that death occurred at 9:10 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Read H. Calvert M.D.	7894 Ga. Ave. Silver Spring Md.	

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb 15, 1949	Glenwood Cem.	Washington,	D.C.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/13/49	[illegible]	Gilbert Walker	Takoma Park D.C.

RECEIVED
FEB 15 1949
BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Montgomery, MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Gaithersburg
LENGTH OF STAY (in this place) 1 Year
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montgomery, General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Gaithersburg, MD
STREET ADDRESS (If rural, give location) Olney, MD.

3. NAME OF DECEASED (Type or Print) (First) Eliza (Middle) (Last) R idgley

4. DATE OF DEATH (Month) Feb. (Day) 17 (Year) 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH Aug. 6 1880

9. AGE last birthday 68 yrs. If under 1 year Months 5 Days 6 | If under 24 hrs. Hours 11 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Domestic

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Montgomery, CO. MD.

12. CITIZEN OF WHAT COUNTRY? U. S A.

13. FATHER'S NAME Unknown- John Evely

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. NO

17. INFORMANT William Ridgley

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Intrd cranial Hemorrhage	11 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive-Cardio-Vascular Disease	Unknown
	(c) Obesity	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 17, 1949, to Feb. 17, 1949, that I last saw the deceased alive on Feb. 17, 1949, and that death occurred at 9:10 p.m., from the causes and on the date stated above.

SIGNATURE Jack Schumacher (Degree or title) M.D. ADDRESS Laytonsville, Md. DATE SIGNED 20 Feb. 49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Feb. 21

NAME OF CEMETERY OR CREMATORY Providence Howard CO

LOCATION (City, town, or county) (State) Howard CO, MD.

DATE REC'D BY LOCAL REG. Feb 20 -49

REGISTRAR'S SIGNATURE Gertrude B Fawler

24. FUNERAL DIRECTOR ADDRESS Roy W. Barber Laytonsville, MD.

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MAR 11 1949
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John, Md. LENGTH OF STAY (in this place) Unknown	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John, Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 39 Valley Rd	STREET ADDRESS (If rural give location) 39 Valley Rd.

3. NAME OF DECEASED (Type or Print)	(First) Robert	(Middle) B	(Last) Roark	4. DATE OF DEATH	(Month) Feb	(Day) 28	(Year) 1949
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 16, 1888	9. AGE last birthday 60 yrs.	If under 1 year Months 9	Days 12	If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Laborer	10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Watertown, Iowa	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Albert Ross Roark		14. MOTHER'S MAIDEN NAME Margaret (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) WW1	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT U.S.Naval Discharge	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	Found dead in home
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dep Med Exam case, 19....., that I last saw the deceased alive on....., 19....., and that death occurred at ? A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank J. Brosehart MD. Dep Med Exam.		Gaithersburg Md	

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 3/9/49	NAME OF CEMETERY OR CREMATORY Arlington National Cem.	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. 3-7-49	REGISTRAR'S SIGNATURE W. E. Jobes	24. FUNERAL DIRECTOR Robert A. Humphrey	ADDRESS Bethesda Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 9 1949
BUREAU V. S.

01870

EVIDENCE FOR ADDITION # 21 IS ON:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 119 MAR 28 1949

162
47d

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: KENWOOD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 325 Highland Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: KENWOOD
(If outside city or town limits, write RURAL and give nearest town)

Street No. 325 HIGHLAND DRIVE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: HOWARD. AUGUSTINE ROBINETTE

3. (b) Social Security Number

4. Sex: MALE

5. Color or race: W

6.(a) Single, married, widowed, or divorced: MARRIED.

6.(b) Name of ~~husband or~~ wife: SADIE A

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): JUNE 4 1884.

8. AGE: Years 64 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: CHESTER, PA.
(Town, county and state)

10. Usual occupation: STAMP DEALER

11. Industry or business

FATHER
12. Name: Augustine Robinette
13. Birthplace: Flintstone Md.

MOTHER
14. Maiden name: Agnes Boole
15. Birthplace: Milwaukee Wis.

16. Informant: Mrs Sadie A Robinette

Address: 325 Highland Dr KENWOOD, MD

17. Cremation
(Burial, cremation, or removal. Which?)

Date thereof: FEB 3, 1949
(month) (day) (year)

Cemetery or crematory: Crematory Cedar Hill

Location: Suitland, Maryland

18. Funeral director: Jas. Sawkes Sons

Address: 1756 Pa Ave, N.W. Wash. DC

19. 2/3 1949 W. E. Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 1st 1949, at 6 45 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1949, to date 19

and that I last saw him alive on February first 1949

Immediate cause of death	DURATION
Hypostatic Pneumonia	2 days
Due to cancer of spine	4 mo
Due to cancer of lung, primary	8 mo.
Other conditions (3/28/49 abc)	

(Include pregnancy within 3 months of death)

Major findings of operations: Ca of spine
Geo Wash. Univ. Hosp. Date of op. in October

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Walter Perchmann, MD
M. D. or other

Address: 1726 Eyest N.W. Date signed 2-1-49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

RECEIVED
FEB 4 1949
BUREAU V. S.

01871

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 331

CERTIFICATE OF DEATH 830 Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Montgomery
MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Cove
LENGTH OF STAY (in this place): 25 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 4901 Newport Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Cove
STREET ADDRESS (If rural give location): 4901 Newport Ave.,

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Bertie	Lee	Rodman	Feb.	14	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months / Days	If under 24 hrs. Hours / Min.
Female	White	Married	2/14/49	67 yrs.	0	13

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H.W.	xx	Virginia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edwins Hudgins	Annie Cottee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	xxx	Romulus Rodman - Husband

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	Instant.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension with Arteriosclerosis	6 years.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 11, 1949, to Feb 14, 1949, that I last saw the deceased alive on Feb 8, 1949, and that death occurred at 6:25 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Bruce F. Benjamin	M.D.	Bethesda, Md. Maryland	2/15/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/17/49	Fort Lincoln Cemetery	Washington, D.C

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-16-49	W.E. Jobes	Leonard A. Humphrey - Bethesda, Md.	

VS. A15

RECEIVED
FEB 21 1949
BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

EVIDENCE FOR CHANGE IN # 18 IS ON: FILM # G119-3-30-49A

492
109

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY: Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Colesville — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Colesville, Md
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First) Emma (Middle) J (Last) Ross

4. DATE OF DEATH (Month) Feb (Day) 16th (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Nov. 2 1855

9. AGE last birthday: 93 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Benjamin H. Johnson

14. MOTHER'S MAIDEN NAME: Ann Jane Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY No.: none

17. INFORMANT: Alice Smith (Sister)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Virus Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension without Edema

(c) Bronchial Asthma

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): none

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 9, 1947, to Feb, 1949, that I last saw the deceased alive on Feb 16, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Webster Sewell, M.D. ADDRESS Norbeck, Md. DATE SIGNED Feb 19

23. BURIAL, CREMATION REMOVAL (Specify) — DATE: Feb 19 1949 — NAME OF CEMETERY OR CREMATORY: Good Hope — LOCATION (City, town, or county) (State): Colesville, Md

DATE REC'D BY LOCAL REG.: Feb. 19, 1949 — REGISTRAR'S SIGNATURE: Josephine M. Schaeffe — 24. FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: Colesville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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Apr 19

RECEIVED
FEB 25 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

420.1 94a 01873

Reg. Dist. No. 223-

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) 15 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 26 1/2 Carroll Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
STREET ADDRESS (If rural, give location) 26 1/2 Carroll Avenue

3. NAME OF DECEASED (Type or Print) (First) THOMAS (Middle) TENGES (Last) RUNDVOLD

4. DATE OF DEATH (Month) Feb. (Day) 13 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH July 24, 1892
9. AGE last birthday 56 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker
10b. KIND OF BUSINESS OR INDUSTRY Wood Work
11. BIRTHPLACE (State or foreign country) Norway
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Hans Rundvold
14. MOTHER'S MAIDEN NAME Elizabeth Tenges

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.I.
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Malene N. Rundvold

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 1 day.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized arteriosclerosis — ?

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) natural causes
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home (CITY OR TOWN) Takoma Park (COUNTY) Mont. (STATE) Md.
TIME OF INJURY (Month) Feb. (Day) 12, (Year) 49 (Hour) 1 a. m.
INJURY OCCURRED While at Work ☐ Not While At work ☑
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Medical Examiner's, 19..., to Case, 19..., that I last saw the deceased alive on ..., 19..., and that death occurred at 1 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Lynn G. Bauersfeld M.D. ADDRESS Bethesda, Md DATE SIGNED 2-13-49.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Feb 15 1949.
NAME OF CEMETERY OR CREMATORY Arlington National Cemetery
LOCATION (City, town, or county) (State) Arlington, Va.

DATE REC'D BY LOCAL REG. 2/13/49
REGISTRAR'S SIGNATURE J. Milton Dodd
24. FUNERAL DIRECTOR Arthur Walters ADDRESS 254 Carroll St. N.W. Takoma Park, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 15 1949
BUREAU V. D.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

581.0

01874

CERTIFICATE OF DEATH 46f

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural)
LENGTH OF STAY (in this place) 5 mons. 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U S Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Washington, D. C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location) 1016 Mass.Ave., N.W.

3. NAME OF DECEASED (Type or Print): (First) Natale (Middle) (Last) SARINELLI

4. DATE OF DEATH: (Month) February (Day) 2 (Year) 19 49

5. SEX: male

6. COLOR OR RACE: W-US

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 12-25-83

9. AGE last birthday: 65 yrs. If under 1 year: Months 1 Days 7 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Switzerland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: SARINELLI, Louie

14. MOTHER'S MAIDEN NAME: BORRI, Therese

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If year, give war or dates of service): WWI

16. SOCIAL SECURITY NO.

17. INFORMANT: friend: Mr. George Girardi (same address)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Hemorrhage, esophageal	2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) carcinoma, liver	
	(c) Cirrhosis, liver, atrophic	2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 24, 19 48, to Feb. 2, 19 49, that I last saw the deceased alive on Feb. 2, 19 49, and that death occurred at 9:25 A m., from the causes and on the date stated above.

SIGNATURE Wm. A. Dinsmore Jr. (Degree or title) ADDRESS DATE SIGNED

Wm. A. DINSMORE, Jr., LtCdr. MC USN, US Naval Hospital, Bethesda, Md. 2-2-49

23. BURIAL, CREMATION REMOVAL (Specify): burial
DATE: 2-8-49
NAME OF CEMETERY OR CREMATORY: Arlington National
LOCATION (City, town, or county) (State): Arlington, Va.

DATE REC'D BY LOCAL REG. 2-2-49

REGISTRAR'S SIGNATURE Mary C. Patterson

24. FUNERAL DIRECTOR ADDRESS: W.W.CHAMBERS, 1100 Chapin St., N.W., Wash., D.C.

RECEIVED
FEB 8 1949
BUREAU V. S.

01875

153
46e

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery Co.
City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 2-5-'49
Hospital, institution, or street address where death occurred: 8600 Old Georgetown Rd Suburban Hospital
How long in hospital or institution? Since 2-5-'49

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: D.C. County: Montg
City or town: Chevy Chase (If outside city or town limits, write RURAL and give nearest town)
Street No. 3312 Quesada St. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harry F. Sauter
3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Catherine T.
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): MAR. 25, 1869

8. AGE: Years: 79 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: District of Columbia (Town, county, and state)
10. Usual occupation: Retired Newspaperman
11. Industry or business:

FATHER
12. Name: Benford Sauter
13. Birthplace: Alsace Lorraine

MOTHER
14. Maiden name: Catherine Eisenhauer
15. Birthplace: Alsace Lorraine

16. Interment: Elmer F. Sauter
Address: 3312 Quesada St. Chevy Chase, D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 11 1949 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Washington, D.C.
18. Funeral director: Francis Hollins
Address: 3821-14th St. N.W.
19. 2/9 1949 W.C. Jones (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Harry Sauter Feb. 8 19 49 at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 27 1949 to Feb 8 1949 and that I last saw him alive on Feb 7 1949

	DURATION
Immediate cause of death: Malignancy Colon	6 mo.
Due to:	
Due to:	
Other conditions: Peritonitis + Intestinal Obstruction (Include pregnancy within 3 months of death)	5 days

Major findings of operations: Tumor of sigmoid + ruptured bowel Date of op.: Feb 5, 49
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Gilbert B. Rude M.D.
M. D. or other
Address: 3900 Military Rd N.W. Date signed: Feb 8, 49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 11 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01876

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: CHEVY CHASE, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
4510 WALSH ST, CHEVY CHASE, Md.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: MONTGOMERY
City or town: CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4510 WALSH ST.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: MISS CARRIE AMELIA SCHNEIDER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	W	SINGLE.

6.(b) Name of husband or wife: NONE
6.(c) If alive, give age: ..... years
7. Birth date of deceased (mo., day, yr.): APRIL 11 - 1863

8. AGE:

Years	Months	Days	If less than one day
86	11	22	..... hrs. ..... min.

9. Birthplace: WASHINGTON D.C. (Town, county, and state)
10. Usual occupation: RETIRED
11. Industry or business:
FATHER 12. Name: CHRISTIAN SCHNEIDER
13. Birthplace:
MOTHER 14. Maiden name: MARY AMELIA MAYER
15. Birthplace:
16. Informant: MRS. M. A. SCHNEIDER
Address: 4510 WALSH ST. BETHESDA MD
17. Burial, cremation, or removal. Which?: BURIAL Date thereof: FEB. 5/49 (month) (day) (year)
Cemetery or crematory: OAK HILL CEM.
Location: WASHINGTON D.C.
18. Funeral director: Joseph Gawler's Sons
Address: 1766 Pa. Ave. N.W. D.C. 6.
19. 2/4 (Date rec'd by registrar) 1949 W G Jules Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 3 1949, at 7:11 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 1947 to Feb 3 1949 and that I last saw her alive on Feb 2. 1949

Immediate cause of death	DURATION
Congestive Heart Failure	
Due to: Arteriosclerosis	
Due to: Myositis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: William F. Luckett M. D. ~~or other~~
Address: 5000 Reno Rd. Date signed 2-3-49

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
FEB 7 1949
BUREAU T. S.

01877

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 163

CERTIFICATE OF DEATH 47d

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural)
LENGTH OF STAY (in this place): 1 mon. 18 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Washington, D.C. — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural give location): 1405 Somerset Place ✓

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Daniel (Last) SMITH

4. DATE OF DEATH: (Month) February (Day) 19 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white-us

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 10-20-92

9. AGE last birthday: 56 yrs. If under 1 year: Months 3 Days 29 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Transportation Specialist

10b. KIND OF BUSINESS OR INDUSTRY: Civil Service

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: SMITH, John

14. MOTHER'S MAIDEN NAME: SHERIDAN, Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If year, give war or dates of service): WWI

16. SOCIAL SECURITY NO.:

17. INFORMANT: wife: Mrs. Agnes Smith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bronch. pneumonia terminal — Interval between onset and death: days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma Lung right — Months

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 2-4-49

19b. MAJOR FINDINGS OF OPERATION: Carcinoma Lung right

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 31 Dec., 1948, to 19 Feb., 1949, that I last saw the deceased alive on 19 Feb., 1949, and that death occurred at 10 A m., from the causes and on the date stated above.

SIGNATURE R. N. Shelley (Degree or title) R. N. SHELLEY, Cdr. MC USN, ADDRESS US Naval Hospital, Bethesda, Md. DATE SIGNED 2-19-49

23. BURIAL, CREMATION REMOVAL (Specify): burial — DATE — NAME OF CEMETERY OR CREMATORY: Mt. Olivet — LOCATION (City, town, or county) (State): Elizabeth, N.J.

DATE REC'D BY LOCAL REG. 2-19-49 — REGISTRAR'S SIGNATURE: Mary C. Patterson

24. FUNERAL DIRECTOR ADDRESS: Robert A. Pumphrey, 7557 Wisconsin Ave. Bethesda, Md.

RECEIVED
FEB 22 1949
BUREAU V. S.

01878

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

156

CERTIFICATE OF DEATH

46f

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN — LENGTH OF STAY (in this place) 1 year	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase, Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pine View Rest Home	STREET ADDRESS (If rural, give location) 25 East Bradley Lane

3. NAME OF DECEASED (Type or Print)	(First) Hattie	(Middle) Elizabeth	(Last) SNYDER	4. DATE OF DEATH	(Month) Feb.	(Day) 28	(Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Nov. 12, 1877	9. AGE last birthday 71 yrs.	If under 1 year Months. 3	Days 16	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Cooper County, Missouri	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Wm. T. Tally	14. MOTHER'S MAIDEN NAME Louisa A. Tate						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. None	17. INFORMANT Mrs. Herschel Young					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Respiratory Failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Severe Malnutrition, Cancer of Liver?

(c) Arteriosclerosis, Cardiac Decompensation

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/17, 1949, to 2/28, 1949, that I last saw the deceased alive on 2/27, 1949, and that death occurred at 1:35 P.m., from the causes and on the date stated above.

SIGNATURE Frank Y. Jaggers Jr. MD. (Degree or title) ADDRESS 5707 Wisconsin Ave Chevy Chase Md. DATE SIGNED 2/28/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit	DATE 3/2/49	NAME OF CEMETERY OR CREMATORY Walnut Grove	LOCATION (City, town, or county) Booneville, (State) Mo.
DATE REC'D BY LOCAL REG. 2-28-49	REGISTRAR'S SIGNATURE W. E. Jobes	24. FUNERAL DIRECTOR Robert A. Pumphrey	ADDRESS Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
MAR 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

01879

2411 N. Charles Street, Baltimore 420.1

CERTIFICATE OF DEATH 940 Reg. Dist. No. 314

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Wheaton, Md.
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Georgia and Hermitage Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Wheaton
STREET ADDRESS (If rural give location): Georgia and Hermitage Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mabel	Estelle	Staples	Feb.	23,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Female	Wh.	married	Mar. 19, 1886	62 yrs.	11	4		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Washington, D.C.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John F. Padgett	Agnes Dowbiggin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or uoknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	none	Wm. H. Staples Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	2 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Cooditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feby 19, 1949, to Feby 23, 1949, that I last saw the deceased alive on Feby 23, 1949, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
John N. Andrews M.D.	960 Colesville Rd Silver Spring	2nd 2-24-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 25, 1949	Rock Creek	Washington, D.C.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 24, 1949	Josephine M. Schaffer	Warner E. Pumphrey, Inc.	8434 Georgia Ave. Silver Spring, Md.

RECEIVED
FEB 28 1949
BUREAU V. S.

01880

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

466

CERTIFICATE OF DEATH

100b Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)
LENGTH OF STAY (in this place) 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maine COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waterville
STREET ADDRESS (If rural give location) 16 Hillside Avenue

3. NAME OF DECEASED (Type or Print) (First) William (Middle) I (Last) STERLING

4. DATE OF DEATH (Month) (Day) (Year) February 11 1949

5. SEX male
6. COLOR OR RACE W-US
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH 10-22-71
9. AGE last birthday 77 yrs. If under 1 year Months 3 Days 19 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator operator
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maine
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME STERLING, Charles
14. MOTHER'S MAIDEN NAME LADD, Eleanor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If year, give war or dates of service) Sp.Am.
16. SOCIAL SECURITY NO. 00522620
17. INFORMANT wife: Mrs. W. I. Sterling

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Embolism, massive, bilateral

Antecedent cause(s) (b) secondary to phlebothrombosis of right leg

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 1, 1949, to Feb. 11, 1949, that I last saw the deceased alive on Feb. 11 1949, and that death occurred at 3:53 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Wm. W. Miller, Jr. Wm. W. MILLER, Jr., Lt. MC USN, US Naval Hospital, Bethesda, Md. 2-12-49

23. BURIAL, CREMATION REMOVAL (Specify) burial Removal
DATE Feb. 13, 1949
NAME OF CEMETERY OR CREMATORY
LOCATION (City, town, or county) (State) Waterville, Maine

DATE REC'D BY LOCAL REG. 2-12-49
REGISTRAR'S SIGNATURE Mary C. Patterson
24. FUNERAL DIRECTOR W W Chambers Co. ADDRESS C.A.P.
W. W. CHAMBERS, 1400 Chapin St., N.W. Wash., D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

01881

2411 N. Charles Street, Baltimore 151

CERTIFICATE OF DEATH 46 Reg. Dist. No. 216

1. PLACE OF DEATH
COUNTY Montgomery Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospitals

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Boyds
STREET ADDRESS (If rural give location) R.R. #2

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) Stevars (Last)

4. DATE OF DEATH (Month) 2 (Day) 16 (Year) 1949

5. SEX M

6. COLOR OR RACE Wh.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH (?) 12-25-72

9. AGE last birthday (?) 76 yrs. If under 1 year Months Days; If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Construction work

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Penbrook, Giles Co. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A. or N. America

13. FATHER'S NAME Samuel Stevars

14. MOTHER'S MAIDEN NAME Lucy Jennings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT son — Alfred Stevars

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac vascular Failure — Interval Between Onset and Death: 24 hours

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma of Stomach with Metastases. — 6 months

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 2-15-49

19b. MAJOR FINDINGS OF OPERATION Carcinoma of Pylorus and of Stomach with metastases

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8 Feb, 1949, to 16 Feb, 1949, that I last saw the deceased alive on 16 Feb, 1949, and that death occurred at 8:30A m., from the causes and on the date stated above.

SIGNATURE Owen Swathmey (Degree or title) M.D. ADDRESS Suburban Hosp. DATE SIGNED 2-16-49 Md.

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 2/18/49 | NAME OF CEMETERY OR CREMATORY Boyds Presbyterian | LOCATION (City, town, or county) Boyds (State) Md.

DATE REC'D BY LOCAL REG. 2/18/49 | REGISTRAR'S SIGNATURE W. E. Jones | 24. FUNERAL DIRECTOR Wm. B. Hilton ADDRESS Barnesville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 24 1949
BUREAU V. S.

01882

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1

CERTIFICATE OF DEATH

93d Reg. Dist. No. 223-

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (In this place) 29 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Cleveland Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Montg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
STREET ADDRESS (If rural, give location) 14 Cleveland Ave.

3. NAME OF DECEASED (Type or Print) (First) ARTHUR (Middle) MORTON (Last) TERRILL

4. DATE OF DEATH (Month) FEB. (Day) 23, (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH APR 27, 1862

9. AGE last birthday 86 yrs. If under 1 year Months — Days — If under 24 hrs. Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter - Bookkeeper

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Roneys Point, W. Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME CHARLES SIMS TERRILL

14. MOTHER'S MAIDEN NAME CIELANN MARLING.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT MRS ELLA S. TERRILL - WIFE.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocarditis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis Generalized

(c)

INTERVAL BETWEEN ONSET AND DEATH: 6 Months. several years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct., 1949, to 23 Feb., 1949, that I last saw the deceased alive on 19 Feb., 1949, and that death occurred at 5 45 P m., from the causes and on the date stated above.

SIGNATURE G B Queen (Degree or title) M.D. ADDRESS 112 Willow Ave. Takoma Park, Md. DATE SIGNED 23 Feb. 1949

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL

DATE THEREOF FEB 26, 1949

NAME OF CEMETERY OR CREMATORY STONE CHURCH CEMETERY

LOCATION (City, town, or county) ELM GROVE, (State) W. VA.

DATE REC'D BY LOCAL REG. 2/23/49

REGISTRAR'S SIGNATURE J Wilson Dodd

24. FUNERAL DIRECTOR J Arthur Walters ADDRESS 254 Carroll St. N.W. Takoma Park, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 23 1949
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

01883

2411 N. Charles Street, Baltimore 430.1

CERTIFICATE OF DEATH 936 Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural) | LENGTH OF STAY (in this place) 2 mos. 27 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS USNH, Bethesda, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyattesville
STREET ADDRESS (If rural give location) 3803 Powhatan Road

3. NAME OF DECEASED (Type or Print): (First) Grant (Middle) (n) (Last) THOMPSON

4. DATE OF DEATH: (Month) February (Day) 25 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 8-31-1871

9. AGE last birthday: 77 yrs. | If under 1 year: Months 5 Days 21 | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Navy Bank

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Ill.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: THOMPSON, Wm. J.

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial Insufficiency

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Arteriosclerotic Heart Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 28, 1949, to Feb. 25, 1949, that I last saw the deceased alive on Feb. 25, 1949, and that death occurred at 5:20 P m., from the causes and on the date stated above.

SIGNATURE D. E. Billman — (Degree or title) D. E. BILLMAN, Lt. JG MC USN — ADDRESS USNaval Hospital, Bethesda, Md. — DATE SIGNED 2-26-49

23. BURIAL, CREMATION, REMOVAL (Specify): burial | DATE 3-1-49 | NAME OF CEMETERY OR CREMATORY: National Arlington Cemetery | LOCATION (City, town, or county): Arlington, | (State): Virginia

DATE REC'D BY LOCAL REG. 2-26-49 | REGISTRAR'S SIGNATURE Mary C. Patterson

24. FUNERAL DIRECTOR: W. W. CHAMBERS — ADDRESS 1400 Chapin St., Wash, D.C.

RECEIVED
MAR 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 153 01884

CERTIFICATE OF DEATH 462

Reg. Dist. No. 215

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

I

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural)
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, D. C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location) 7 18th St., S.E. ✓

3. NAME OF DECEASED (Type or Print): (First) Thomas (Middle) Moore (Last) THORNTON
4. DATE OF DEATH (Month) February (Day) 1 (Year) 1949

5. SEX: male
6. COLOR OR RACE: W-US
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: 8-3-95
9. AGE last birthday: 53 yrs. If under 1 year: Months 5 Days 28 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10b. KIND OF BUSINESS OR INDUSTRY: US Government
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: THORNTON, Robert L.
14. MOTHER'S MAIDEN NAME: DAY, Mamie M.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If year, give war or dates of service): WWI
16. SOCIAL SECURITY NO.:
17. INFORMANT: wife: Mrs. Catherine E. Thornton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cachexia	2 mos.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinomatosis	9 mos.
	(c) Carcinoma of Colon	8 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 31, 1949, to Feb. 1, 1949, that I last saw the deceased alive on Feb. 1, 1949, and that death occurred at 10:44 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W. F. HARRISON, Jr., Lt. MC USN, US Naval Hospital, Bethesda, Md. 2-3-49

23. BURIAL, CREMATION REMOVAL (Specify): burial
DATE: 2-4-49
NAME OF CEMETERY OR CREMATORY: Arlington National
LOCATION (City, town, or county) (State): Arlington, Va.

DATE REC'D BY LOCAL REG. 2-1-49
REGISTRAR'S SIGNATURE: Mary G Patterson
24. FUNERAL DIRECTOR: W. W. CHAMBERS, ADDRESS: 517 11th St., S.E. Wash., D.C.

VS. A15

RECEIVED
FEB 4 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01885

153

462

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural)
LENGTH OF STAY (In this place): 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: N.C. — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Wilmington
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Blanche (Middle) Stewart (Last) WALSH

4. DATE OF DEATH: (Month) February (Day) 5 (Year) 1949

5. SEX: female

6. COLOR OR RACE: W-US

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 5-24-10

9. AGE last birthday: 38 yrs. — If under 1 year: Months 8, Days 11 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): N.C.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: STEWART, ?

14. MOTHER'S MAIDEN NAME: WADE, Victoria

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: US Naval Air Station, Norfolk, Va. husband: Lt.Comdr. H. L. Walsh, USN

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Carcinoma sigmoid with metastases	5 mo.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pulmonary atelectasis	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Oct. 1948

19b. MAJOR FINDINGS OF OPERATION: Scirrhous carcinoma sigmoid

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 4, 1949, to Feb. 5, 1949, that I last saw the deceased alive on Feb. 5, 1949, and that death occurred at 8:13 A m., from the causes and on the date stated above.

SIGNATURE: J. J. ZUSKA (Degree or title): Cdr. MC USN ADDRESS: US. Naval Hospital, Bethesda, Md. DATE SIGNED: 2-5-49

23. BURIAL, CREMATION, REMOVAL (Specify): burial
DATE THEREOF: 2-9-49
NAME OF CEMETERY OR CREMATORY: Arlington National
LOCATION (City, town, or county) (State): Arlington, Va.

DATE REC'D BY LOCAL REG.: 2-5-49
REGISTRAR'S SIGNATURE: Mary C. Patterson

24. FUNERAL DIRECTOR ADDRESS: W. W. CHAMBERS, 1100 Chapin St., N. W. Wash., D.C.

RECEIVED
FEB 8 1949
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01886

570.2
122

CERTIFICATE OF DEATH

Reg. Dist. No. 217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, is especially important. Physicians: please write the causes of death clearly and legibly. The correct age

1. PLACE OF DEATH: COUNTY Montgomery; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Colesville; LENGTH OF STAY (in this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS Montgomery Co General Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Colesville; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Sadie (Middle) Warren (Last)

4. DATE OF DEATH: (Month) 2 (Day) 20 (Year) 1949

5. SEX: F

6. COLOR OR RACE: Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 9/23/91

9. AGE last birthday: 57 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME: William Henry Reedy

14. MOTHER'S MAIDEN NAME: Annie Dent

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mary Watts

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Intestinal Obstruction — Interval Between Onset and Death: 7 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Mesenteric Thrombosis — 8 -

(c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: 2/21/49

19b. MAJOR FINDINGS OF OPERATION: Gangrenous 6 ft of ileum. Resected

20. AUTOPSY? Yes X No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): — (CITY OR TOWN): — (COUNTY): — (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 2/13/49, to 2/20/49, that I last saw the deceased alive on 2/20/49, and that death occurred at 6:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J W Burt M.D. ADDRESS Sandy Spring Md DATE SIGNED 2/20/49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE 2/23/49 | NAME OF CEMETERY OR CREMATORY Rock Hope | LOCATION (City, town, or county) (State) Colesville, Md

DATE REC'D BY LOCAL REG. 2-22-49 | REGISTRAR'S SIGNATURE Gertrude B Sawler | 24. FUNERAL DIRECTOR Robert L. Snowden | ADDRESS Rockville Md

VS. A15

RECEIVED
MAR 11 1949
BUREAU F. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1 01887

CERTIFICATE OF DEATH

94a Reg. Dist. No. 218

1. PLACE OF DEATH: COUNTY Montg, Co, MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington Grove
LENGTH OF STAY (in this place) 6yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montg
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington Grove,
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) William (Middle) Alexandria (Last) Waters

4. DATE OF DEATH (Month) Feb (Day) 24 (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Nov 15th 1890

9. AGE last birthday 58 3 yrs. If under 1 year Months. 9 Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage Service

10b. KIND OF BUSINESS OR INDUSTRY Autto Dealer

11. BIRTHPLACE (State or foreign country) Germantown Md, USA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Clark Waters

14. MOTHER'S MAIDEN NAME Maud E Gesendinner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT Lillian F, Waters

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: died suddenly

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Def. med 19 Exam case 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 4:00 P. m., from the causes and on the date stated above.

SIGNATURE Frank J. Brosshart (Degree or title) M.D. Def. med. Exam. ADDRESS Gaithersburg Md. DATE SIGNED 2/25/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Feb26/49

NAME OF CEMETERY OR CREMATORY St Marys

LOCATION (City, town, or county) Rockville (State) Md.

DATE REC'D BY LOCAL REG. Feb 25, 1949

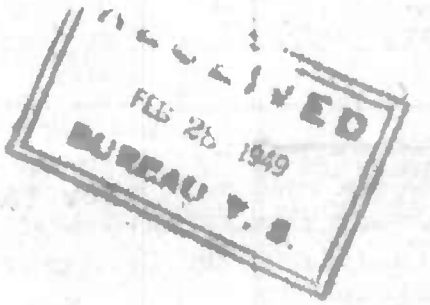
REGISTRAR'S SIGNATURE Alvada G. Cooke

24. FUNERAL DIRECTOR ADDRESS Ernest C, Gartner, Gaithersburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15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FEB 25 1949
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01888

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1630

CERTIFICATE OF DEATH

Reg. Dist. No. 211

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH · COUNTY: Montgomery Co, MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lewisdale, Md. — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lewisdale
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural, give location): Rural

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	Oliver	Watkins	Feb.	9	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	July 19, 1921	27 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, avan if rotired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	~~215-210605~~	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James W Watkins	Cordelia Shipley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, giva war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
	215-210605	Mrs Cordelia E Watkins

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carbon Monoxide Poisoning (suicidal)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
Suicide	Home	Lewisdale,	Mont. Co.	Md.

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED Whila at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Medical Examiner's Case, 19..., to ..., 19..., that I last saw the deceased alive on ..., 19..., and that death occurred at ... m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Emil G. Bauer	Asst. Medical Examiner	Bethesda, Md.	2/9/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb 11, 1949	Bethesda Mem.	Brookeville, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 11, 1949	Della N. Burdette	Roy N. Barber,	Laytonsville, Md.

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 260 01889

CERTIFICATE OF DEATH 61 Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH — COUNTY: MONTGOMERY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BETHESDA; MARYLAND; LENGTH OF STAY (in this place): 45 Minutes; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Suburban Hospital 8600 Old Georgetown Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: MARYLAND; COUNTY: MONTGOMERY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda; STREET ADDRESS (If rural give location): 5520 Alta Vista Road

3. NAME OF DECEASED (Type or Print): (First) FLORENCE (Middle) DEAN (Last) White

4. DATE OF DEATH: (Month) FEBRUARY (Day) 12 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: 11-29-1874

9. AGE last birthday: 74 yrs. If under 1 year: Months 2 Days 14 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Fed. Bureau Invest.

11. BIRTHPLACE (State or foreign country): JERSEY CITY, NEW JERSEY

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: GEORGE HENDERSON WHITE

14. MOTHER'S MAIDEN NAME: MARY EMMA DEAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT: SISTER. MRS. GRACE D. JOHNSON

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Diabetic coma — 20 hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Diabetes mellitus

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral arteriosclerosis

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1946, to 2-12, 1949, that I last saw the deceased alive on 2-12, 1949, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Samuel E. Mahler, M.D. | 8712 Georgetown Rd, Bethesda, Md. | 2-12-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 2/15/49 | NAME OF CEMETERY OR CREMATORY: Rockville Union Cem | LOCATION (City, town, or county) (State): Rockville Md.

DATE REC'D BY LOCAL REG. 2-14-49 | REGISTRAR'S SIGNATURE: W.E. Jobes | 24. FUNERAL DIRECTOR: Robert A. Pumphrey. | ADDRESS: Bethesda, Md.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 223-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASH. SAN. & HOSP.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington — COUNTY DC
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural give location) 110 Van Buren St. NW

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) LA RUE (Last) WHITE

4. DATE OF DEATH: (Month) Feb. (Day) 2 (Year) 1949

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH: Jan 6, 1883 | 9. AGE last birthday: 66 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired G.A.O. Employee | 10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government | 11. BIRTHPLACE (State or foreign country): Barnstown, Md. | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Howard White | 14. MOTHER'S MAIDEN NAME: Celia Virginia Trundle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Uremia — 14 Days.

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Valvular Heart Disease due to Acute Endocarditis — 2 years.

(c) Chronic Bronchitis and Bronchiectasis — 20 years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — | 19b. MAJOR FINDINGS OF OPERATION — | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — | (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5 Jan., 1949, to 2 Feb., 1949, that I last saw the deceased alive on 1 Feb., 1949, and that death occurred at 3 30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

J. B. Queen M.D. 112 Willow Ave. Takoma Park, Md. 2 Feb. 1949.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE Feb. 4 1949 | NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | LOCATION (City, town, or county) Washington, (State) D.C.

DATE REC'D BY LOCAL REG. 2/2/49 | REGISTRAR'S SIGNATURE J. Hilton Dodd

24. FUNERAL DIRECTOR J. Luther Walters | ADDRESS 254 Carroll St. NW. DC

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH · COUNTY: Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Wash., D.C. COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural) — LENGTH OF STAY (in this place): 10 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital	STREET ADDRESS (If rural give location): 3319 Brothers Place, S.E., Apt. #1

3. NAME OF DECEASED (Type or Print) (First) Daniel	(Middle) Boone	(Last) Wilson	4. DATE OF DEATH (Month) Februrary	(Day) 4	(Year) 1949
5. SEX: male	6. COLOR OR RACE: W-US	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: 6-23-62	9. AGE last birthday: 86 yrs.	If under 1 year: Months 7, Days 10; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pensioner	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Virginia	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME: unknown		14. MOTHER'S MAIDEN NAME: unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If year, give war or dates of service): Sp. Am.	16. SOCIAL SECURITY NO.	17. INFORMANT: nephew: Mr. Edgar H. Wilson			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Embolism secondary to Surgery

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 2-3-49	19b. MAJOR FINDINGS OF OPERATION: Benign Prostatic Hypertrophy	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 24, 1949, to Feb. 4, 1949, that I last saw the deceased alive on Feb. 4, 1949, and that death occurred at 9:02 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm. W. Miller Jr.	Wm. W. Miller, Jr., Lt. MC USN,	US Naval Hospital, Bethesda, Md.	2-5-49

23. BURIAL, CREMATION REMOVAL, (Specify): burial	DATE: Feb 7, 1949	NAME OF CEMETERY OR CREMATORY: Upperville Cemetery	LOCATION (City, town, or county) (State): upperville, Va.
DATE REC'D BY LOCAL REG.: 2-5-49	REGISTRAR'S SIGNATURE: Mary C. Patterson	24. FUNERAL DIRECTOR: Edders Funeral Home, Berryville, Va.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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FEB 8 1949
BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

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13b

Reg. Dist. No. Y14

1. PLACE OF DEATH:

County MONTGOMERY

City or town SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 MONTHS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY

City or town SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)

Street No. 802 PHILADELPHIA AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME HANS W. WOLLENWEBER

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWER

6.(b) Name of husband or wife FRIEDA WOLLENWEBER

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) SEPT. 9, 1879

8. AGE: Years	Months	Days	If less than one day
69	4	24	..... hrs. ..... min.

9. Birthplace GERMANY
(Town, county, and state)

10. Usual occupation NONE

11. Industry or business

FATHER
12. Name GEORG WOLLENWEBER
13. Birthplace GERMANY

MOTHER
14. Maiden name LAURA
15. Birthplace GERMANY

16. Informant MRS. LORE W. SCHRIDER

Address 802-PHILA. AVE. SILVER SPRING MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 5, 1949 (month) (day) (year)

Cemetery or crematory Mt Olivet Cemetery

Location Washington, D.C.

18. Funeral director Francis J. Collins

Address 3821-14th St. Nw. Wash. D.C.

19. Feb 5 1949 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 3, 1949, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DECEMBER 31 1948, to FEBRUARY 3 1949 and that I last saw him alive on FEBRUARY 3 1949

	DURATION
Immediate cause of death CONGESTIVE HEART FAILURE	
Due to MYOCARDITIS	
Due to MALNUTRITION	
Other conditions PULMONARY TUBERCULOSIS (Include pregnancy within 3 months of death)	

Major findings of operations NONE

Date of op. —

Autopsy results NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Marshall Leuvillier Jr. Wtd M. D. or other

Address 8648 GEORGIA AVE SILVER SPRING, MD Date signed FEB. 3, 1949

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

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BUREAU V. S.

01893

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 420.1 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — STATE MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pennsylvania — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park — LENGTH OF STAY (in this place) 11 days.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hanover
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium	STREET ADDRESS (If rural give location) 188 2nd Ave. ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John	William	Young	2	3	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	3-28-84	64 yrs.	11			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Auditor		Meyersdale, Pa	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John W. Young Sr.	Annie Schnable.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	Terminal 2 Minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	? years
	(c) Arteriosclerosis	? years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes Mellitus	? years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ....., 1944, to Feb 3, 1949, that I last saw the deceased alive on Feb 3, 1949, and that death occurred at 10:00 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Robert A Hare	M.D.	Takoma Park Md.	2/4/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	2/7	Mt Olivet	York Co. Hanover Pa

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/4/49	J Wilson Todd	Robert A. Pumphrey	Beth. Md.

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